University of Alberta

Educating publics and policy makers: Epistemic communities and the politics of evidence-based health reform in Alberta and Saskatchewan

by

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Dedication

This thesis is dedicated to Dr. Matthew Spence who made this study possible through his encouragement and support. His vision, leadership, and steadfast commitment to excellence in research is an inspiration to all those who had the privilege of working with him.

Abstract

This thesis studies the politics of evidence-based health reform in Alberta and Saskatchewan between 1987 and 2003. The objective was to develop a theory and model to enhance the practice of policy makers, researchers, politicians, and citizens. The thesis examines how knowledge is used in public policy making, the relationship of knowledge and health reform, how legitimate knowledge is identified, and the relationship of facts and values. Normative and prescriptive approaches are advanced through: (a) grounded theory and case study, (b) social and political theorizing, and (c) generating metatheory. Semistructured interviews were conducted with politicians, policy makers, researchers, and citizen elites from Alberta and Saskatchewan ($n = 24$) in 2003 to determine the informant's view of the interplay among scientific evidence, values, opinions, and ideology in policy making.

Perspectives differed on what constituted scientific evidence and how it should be used in policy making. All agreed high-quality evidence (HQE) is necessary and of increasing importance, although a paradox was noted between the expressed value of using evidence and policy actions. Politicians and researchers (particularly in Alberta) identified a chasm in the appreciation of each other's role. Barriers and confounding factors compromising the effective uptake of HQE were identified. A distinction between what constitutes HQE and low-quality evidence was established. Informants' ability to discriminate between and among constituents of HQE (scientific evidence, values, ideology, and opinions) was generally weak, although all agreed a consistent approach was essential to avoid narrow interests and local contextual factors dominating and confounding the policy-making process. The model developed aims to facilitate effective policy making through four primary thrusts: (a) best practice in research and policy making; (b) effective linkage and interaction among actors; (c) transparent and open accommodation of dissonance among scientific evidence, ideology, values, and opinion; and (d) effective traction of the policy-making process moving toward improving population health status. Two other tools were developed from the theory: (a) the STEEPLE model to improve policy makers' utilization of the social sciences and (b) best practice checklists for policy making, linkages, accommodation, and traction. The thesis concludes with recommendations for future health policy research.

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Abbreviations

AHFMR – Alberta Heritage Foundation for Medical Research

CCHSE – Canadian College of Health Service Executives

CCOHTA – Canadian Coordinating Office for Health Technology Assessment

CHSRF – Canadian Health Services Research Foundation

CIHI – Canadian Institute for Health Information

CIHR – Canadian Institutes of Health Research

CPHI – Canadian Population Health Initiative

EBDM – Evidence-based Decision Making

GT – Grounded Theory

HQE – High-Quality Evidence

HSR – Health Services Research

HSURC – Health Services Utilization Review Commission

HTA – Health Technology Assessment

IRPP – Institute for Research on Public Policy

LQE – Low-Quality Evidence

MRI – Magnetic Resonance Imaging

MS – Multiple Sclerosis

NDP – New Democratic Party

NGOs – Nongovernmental Organizations

OECD – Organisation for Economic Co-operation and Development

RCT – Randomized Control Trial

SARS – Severe Acute Respiratory Syndrome

SEARCH – Swift Efficient Application of Research in Community Health

SECTION ONE: KNOWLEDGE AND HEALTH CARE REFORM

Two chapters form section 1. Chapter 1 introduces the subject, structure, research design, and problematics that were interrogated in the thesis. The chapter iterates the research question as well as three subproblems and describes the three major approaches to the analysis of knowledge and health reform: grounded theory (GT), generating metatheory, and social and political theorizing. The key variables, assumptions, and procedures used to interrogate the research question are described. The chapter concludes with a description of a disciplined six-stage approach to policy analysis.

Chapter 2 undertakes to reframe the contemporary discourse surrounding the creation and use of knowledge to inform policy questions in health care reform because current circumstances have led to a stalemate. Insights into appreciating different forms of knowledge are exposited. Issues arising from the relationship between reality and forms of knowledge, the role and utilization of research in policy making, and the position of ideology and values are examined with a view to identifying mechanisms for introducing them into the dialogue with scientific evidence to inform health reform. The chapter explains why focusing only on the development and application of traditional scientific evidence to inform the health reform policy enterprise will not materialize in significant gains in health benefits for citizens.

Chapter One

Introduction

What is the study about?

In this study, I explain the role of high-quality evidence (HQE), ideology, values, and opinions in the policy-making process during health care reform in Alberta and Saskatchewan from 1987 to 2003. The study is important because of the debate that arises from what is and what may be considered legitimate knowledge to inform policy making in health reform. In Canada, as in many other countries around the world, the question of the best way to reform a health care system is a topic of considerable contemporary interest. The debate centres on whether health care delivery should be a public, private, or mixed service and how that should be determined, funded, and delivered. What is the most appropriate mix? What type of knowledge is given legitimacy and primacy in the policy-making process, may dictate to a considerable extent the outcomes of the process. This study analyzes the dynamics surrounding the controversy of what counts as legitimate knowledge and how this may influence the policy making of health reform.

The research question posed in this study is, "What was the interplay among evidence, values, ideology, and opinions during health reform in Alberta and Saskatchewan during 1987 and 2003, and how can this knowledge help inform politicians, policy makers, researchers, and citizens on how to improve the health care policy-making process in the future?" The broad public policy problem is that the current health reform process appears to have reached an impasse or stalemate in improving health care delivery to citizens. This impasse has two dimensions. The first is the practical problem of health care policy making continuing to serve the public interest. The second is a research problem associated with identifying what counts as knowledge to inform the health reform process. This research problem can be analyzed to expose three empirical subproblems, each with a related normative question: (a) What is the relationship between knowledge and health reform, and what should it be? (b) What is knowledge, and how should the demarcation of legitimate knowledge from illegitimate knowledge be adjudicated? and (c) What is the relationship of fact and value, and what should the relationship of fact and value be and how should it be established? The next chapter explicates these problematics by reviewing the related literature and by reframing the policy and research problems.

The research question is worth exploring because of the questions and issues that have arisen surrounding the effective uptake of scientific evidence and about the effectiveness of knowledge use and the delivery of health care interventions. On the one hand, health sciences and services researchers are often frustrated by the unwillingness of policy makers and politicians to take up and act on what they perceive as being "obvious" courses of public choice. On the other hand, policy makers often find that researchers are naively unaware of the pragmatic considerations that go into undertaking a health reform initiative. It is this gap in understanding and appreciating the respective world views of policy makers, politicians, researchers, and citizen elites that is an important part of the focus of this study. The ultimate objective of the thesis was to derive a model or theory that would assist in closing the gap among what appear on the surface to be irreconcilable different views of the parties. An elaboration and application of these resulting models informs the concluding discussions in chapters 11 and 12 of the thesis.

What are the key variables in the study?

Many dynamic variables inform what comes to be identified as knowledge to inform policy making in health care reform. The two cases explored here, Alberta and Saskatchewan, were selected for an in-depth analysis and for comparative purposes because of their similarities and differences. The first series of variables were selected to focus on the social actors or epistemic communities that had a significant role in health care reform policy making. For the moment, and to be developed in more detail later, epistemic communities are defined in this study as groups with a shared set of normative and principled beliefs serving as a value-based rationale for social action. The epistemic communities selected for this study were politicians, policy makers, researchers, and citizen elites. A second series of variables were the different forms of knowledge that are often transacted and debated in the course of health reform policy making. The variables were HQE, ideology, values, and opinions. The study identifies and analyzes the character of the two cases and analyzes the similarities and differences among the multiplicity of variables with a view to arriving at a model or theory that would help to understand the relationships among knowledge, values, and health care reform and to suggest ways to close the gap among the epistemic communities. In explicating these relationships, the thesis focuses on several key questions: What did politicians perceive to be HQE? How did this compare and contrast with the perceptions of policy makers, researchers, and citizens elites? How did the respective epistemic communities perceive the influence of ideology, values, and opinions on health reform policy making? Did they differentiate among them? How did they do so? The study provides a glimpse and understanding of what are often considered to be common concepts, but actually are vastly different.

What are the assumptions of the study?

The study makes a number of assumptions regarding generalizability of findings, particularities of the chosen epistemic communities, scope of the influences, and historical relevance. The first assumption is that by studying Alberta and Saskatchewan in detail, a better understanding of health reform in the two provinces would be achieved. However, broader questions and issues of public policy (of which heath care policy making is but a component) were not addressed. In addition, because these are two outlier provinces, there may be limited generalizability to the other provinces in Canada.

The second assumption is that by studying the selected epistemic communities – politicians, policy makers, researchers, and citizen elites – a fuller understanding of the dynamics of health care policy making could be identified. This cannot be presumed – an understanding of the selected perspectives of the epistemic communities was gained but no pretense is made that these serve as more universal viewpoints necessarily shared by others.

A third assumption is that HQE, ideology, values, and opinions are the only forms of knowledge exchanged and transacted. The fact is that other forms of knowledge are present but ignored, for example, personal beliefs; however, in some cases these alternative forms of knowledge may be captured within other categories, such as values and/or ideology.

A final assumption of this study is that the period from 1987 to 2003 is treated as more historically and politically relevant then other periods when it comes to the study of health reform and policy making. The period was selected because it does offer an examination of a period in which the full cycle from a provincially commissioned review to implementation of findings did take place. However, it should be noted that 2003 as the endpoint of this study is somewhat arbitrary and that health reform continues to evolve in the provinces. In spite of these assumptions, Alberta and Saskatchewan provide two excellent cases because of their contrasting political, historical, and social circumstances.

What were the procedures applied to explore the question?

This research follows the qualitative tradition. The research design integrates three major approaches to studying the relationship between knowledge and health care reform: grounded theory (GT), metatheorizing, and social and political theorizing. The first approach uses GT to study the role and perspectives of individuals and their attendant ideas, institutions, and instruments that created the politics of evidence-based health care policy making. GT facilitates the study of the interaction and relationships of social actors. Through the process of interviews, data were collected to help describe and explain the interactions among the actors. The second approach of metatheorizing takes an historical and conceptual approach to epistemic issues and problematizes the narrow way that knowledge has been construed in traditional approaches to HQE, health, and political reform. This analysis adds reflexive depth to what is usually a naive approach to "best knowledge" and introduces a postpositivist treatment of knowledge use focused on pragmatism and drawing from elements of poststructuralism and critical theory. The third approach, social and political theorizing, interrogates the case material by drawing from social and political theory with a particular emphasis on theories of the state. The theoretical analysis also adds reflexive depth to the study by explicating some of the empirical and normative assumptions that inform contemporary health care debate but are rarely acknowledged other than in simplistic self-evident assertions. In keeping with an emphasis on a communication strategy to move the policy debate forward, the thesis promotes a normative model based on deliberative democracy that is consistent with a liberal democratic constitutional order. These three approaches are triangulated throughout the thesis to enhance different levels of analysis and are further elaborated in section 2 of the thesis on research design.

The University of Alberta Research Ethics Board approved the project on March 4, 2003. Eighteen questions formed the core questionnaire, which was prepared and validated through a trial run with two independent informants familiar with the roles of the four actors in health care policy making. The GT approach to research supported with metareflexive theorizing on epistemic frameworks and social and political theories is consistent with George (1979) who states, "From the statistical (and survey) research model, this method borrows the device of asking a set of standardized, general questions of each case….using a standardized set of questions in the controlled comparison is necessary to assure acquisition of comparable data from the several cases" (George, 1979, p. 28). The explication of ways to approach epistemic frameworks and social and political theorizing further supplements the standardization of debates about the nature and function of data during the research process. Thus situated, purposeful sampling was used to select 24 informants for interviews. In its broadest sense, the comparative case study project is positioned as a pragmatic postpositivist approach to policy analysis with a critical eye for tacit intellectual frameworks that shape political debates and a practical intent to identify a prescriptive method or theory for improving policy making.

What is the structure of the argument?

The thesis and the research design problematizes key questions about the nature of legitimate knowledge and its relationship to values that inform health care policy making on two levels: representational and critical. The first level is *representational* because it describes what is currently considered to be HQE and how HQE relates to the policy process. At a second level, in what I call the *critical level of analysis*, I problematize the self-evident notion that "good" evidence is easy and simple to ascertain. I ask: What is it that legitimates knowledge and gives it a privileged position relative to policy making? Is that position appropriate or deserved?

The study emphasizes both the representational and critical levels of reflexivity because I assume that if this study is to advance our thinking and application of how to improve the creation, assessment, and application of HQE to health care policy making, it must do so from something more than a declarative stance that assumes that traditional scientific evidence is both self-evident and enough to advance the policy-making process. Contemporary studies that focus on the representational character of knowledge utilization in policy making end up simply reflecting the social dynamics as they currently exist. Thus another key assumption of this study is that not only is more thinking and discussion required, but also better thinking and discussion is required, and central to this "better" is rethinking the nature of embodied, practical, and discursive knowledge, as well as broadening the scope of the kinds of knowledge that can find legitimacy in the deliberative democratic process. Domains of knowledge from the humanities and/or social sciences are currently underutilized in health care policy making. To advance our thinking, a critical approach to what is considered knowledge and how it is treated is undertaken with a view to creating a pragmatic way forward.

What contribution does the study make to theory and practice?

This study is a response to four gaps in the research literature and practice environments and will be addressed in more detail in the next chapter. First, many studies examining knowledge creation and transfer in policy making tend to group politicians and government bureaucrats into one category as "policy makers." This study discriminates between the two groups in an effort to more sensitively appreciate their respective needs and motivations. Second, many studies tend to focus and examine the transfer of newly created knowledge between the research community and the policy community without taking into account the more general level of knowledge and sentiment of citizens on the issues or the implications of the disparity between the two on the success of the policy-making process. The perspective of citizen elites, whose role assigned by the legislature is to protect citizen interest, is taken into account in this study. Third, many studies characterize the protection or promotion of interests (personal, organizational, and professional) as being an instrumental barrier to the effective transfer and implementation of knowledge. Political scientists have differentiated barriers to implementation of new knowledge into three categories: interests, institutions, and ideas. This study attempts to elevate and reorientate the analysis away from interests and institutions and toward the mediation and mitigation of ideas like HQE, values, ideology, and opinions. This project does not deny the relevance and importance of interests and institutions, but reframes and differentiates interests into four types of "ideas" that are negotiated in the health care policy settings – evidence, ideology, values, and opinions. Fourth, the research literature has made significant progress in identifying best practice in the research community; however, very little has been exposited about what constitutes best practice in the health policy-making community. This project addresses the issue of best practice in policy making. The objective of the project is to develop a model or theory that will assist policy makers and researchers to work more effectively with HQE, values, ideology, and opinions in order to improve the delivery of health care and ultimately the health of citizens.

Presentation logic of the thesis

Stages of the thesis

The written thesis can be described as having been developed along six stages. Each of the stages reflects a movement between two levels of thinking: an empirical and representational approach on the one hand and a metareflexive and critical approach on the other. I wish to highlight that this outline of stages is an attempt to capture my logic of presentation and should not be confused with my logic of interpretation, that is, the way I collected and analyzed my data as a hermeneutic process. I detail my logic of interpretation in section 2 under Research Design.

Stage 1: Introducing the problematic

Stage 1 (chapter 1) establishes the research interest in competing approaches to knowledge and health care reform and my normative commitments to deliberative democracy. My normative perspectives are induced from my experiences working as an administrator in the health care system; the GT approach of the case studies; and the narrative histories examining the development of the Canadian health care system, with a particular focus on Alberta and Saskatchewan. The critical level of analysis in this study is derived from my social and political theorizing, problematizing knowledge through the generation of metatheory, and culminating in my theorizing and model building.

During the research process, my own understanding and appreciation increased regarding the relationship among the four epistemic communities and their perspectives and actions around questions of the legitimacy of knowledge and values and how they interrelated to politics and power. Since each community appears to have a claim on the truth, what is called for is a mechanism to mitigate and mediate the differences and to close the research-to-praxis gap. Traditional forms of scientific knowledge alone are not enough. Two approaches for introducing values and ideology to the policy table discourse are identified, and deliberative democracy is identified as the mechanism to achieve it.

Stage 2: Reframing the policy problem

Stage 2 (chapter 2) frames and reframes the policy problem regarding health care reform, knowledge, and values. Current ways of looking at the policy process stalemate appear to arrive at solutions that do not work. In this thesis, I look at the four epistemic communities and their views on what constitutes legitimate knowledge and how to differentiate between facts and values. A dissonance arises among the four communities at both the normative and prescriptive levels. Archer (2000) provides a way forward with her explanation of three forms of knowledge – embodied, practical, and discursive. This insight helps explain the problems inherent in the interaction among the four epistemic communities. From the interplay between the empirical - normative and prescriptive - dimensions, as well as the theoretical and practical dimensions, a syncretic redefinition of the practical policy problem begins to emerge. Policy actors need to do something to break the stalemate.

Stage 3: Formulating the research design

Stage 3 (chapters 3 to 5) explicates a research design that triangulates three methods to add analytical depth to the research, with the capacity to address the major problematics of the study. By analogy, the research design surrounding knowledge is located at the three points of a triangle: (a) GT, (b) social and political theorizing, and (c) generating metatheory. GT lends itself to micro-level analysis and lays a foundation for inductive theory generation. It provides a disciplined approach to preserving scientific rigour as well as an empirical basis to code, categorize, and conceptualize the data. This allowed me to look at differing perspectives, motives, and actions and provided for a deeper level of reflexivity in addressing the contradictions between stated views and actions.

This approach was linked to general social and political theorizing. I was able to discuss the relationship of truth and value along one axis, and research and praxis along another, leading to a call for best practice in policy making and research through linkages and accommodation. A postpositivist moment was realized with the use of policy archaeology as a way to complement the traditional positivistic knowledge brought to the policy table. Again, deliberative democracy is identified as a mechanism to ameliorate the issues.

The metareflexivity led to a better understanding of the naive approach to the "politics of knowledge" in health care research and reform, as well as the untapped plethora of existing research on the study of "knowledge" from philosophical, historical, and sociological sources. I adopt Weber's (1947) ideal types as a metaphor for best practice, followed by mechanisms for linkages and accommodation that reconciles the bricolage of scientific advice brought to bear. How to separate the wheat from the chaff? Although socially constructed, not all knowledge is equally meritorious. I identify the need for criteria to adjudicate in the domains and fields in order to identify knowledge that is empirically illegitimate.

Here the focus is on the legitimacy of representations not necessarily of reality. How do we answer this? Again, I arrive at deliberative democracy as an appropriate mechanism.

I address the tension between individual liberty and state authority regarding health care delivery and the assumptions that have informed contemporary debates. There are competing ways to explain the reforms. Alberta and Saskatchewan represent outliers. The debate appears to create more heat than light, so I shift away from examining interests to ideas and their resolution through deliberative democracy. In "speaking truth to power" I come on the side of clear demarcation of the respective roles of politicians and bureaucrats but also a plea for international best practice on both accounts. The chapter encourages the social and political theorizing as a supplement to positivistic research to increase the quality of reflexive debate in addressing policy issues. What I expect of others I also expect of myself.

Stage 4: Comparative case studies

Stage 4 (chapters 6 to 10) describes the comparative case studies. I begin with narratives that provide us with a mosaic of ideas associated with historical, political, and social perspectives of health reform in Canada.

What is HQE and how is it used? Each of the epistemic communities has a perception of what constitutes HQE – they are not the same. Politicians think that citizen's opinions need to be taken into account, while researchers feel knowledge needs to be empirically generated and validated. Policy makers find themselves in the position of mediating between the two. Citizen elites appear to be positioned with a good understanding of the mediation that is necessary to balance between doing what is scientifically correct versus what is publicly acceptable. Saskatchewan appears to be better positioned to create and use HQE evidence to inform the policy making than does Alberta, which manifests some characteristics of anti-intellectualism at the policy-making table.

What are the motivators, barriers, and confounding factors to HQE? The study shows that all of the epistemic communities say they are committed to the use of the best evidence to inform policy – however, they qualify this by stating that interests and/or institutions may come in the way. One of the barriers among the epistemic communities is their different perceptions of what constitutes HQE. They also have different motivations – politicians to be popular and researchers to be "right."

What are sources of HQE and how should it be produced? All epistemic communities feel that it should be objective on the one hand, but also responsive to citizen needs. This brings to the fore the debate of the positivists who reflect reality as they see it and the postpositivists who are critical of characteristics of society that are not respectful of democratic principles and citizens achieving their maximum potential. All agreed that evidence should be pursued outside of interference and at arm's length. However, it should also be noted that there are interests that produce evidence to support their particular values and ideology. In looking to what is best in the citizen interest, a healthy challenge function appears necessary.

In relation to conflict and resolution among values, opinions, ideology, and HQE, I found that few of the four epistemic communities had mechanisms for being able to discriminate among values, opinions, ideology, and HQE. What criteria are used? Are they explicit, open, and transparent? Is there an opportunity for discourse among them? Participants of both provinces stated a commitment toward these principles – both provinces provided representative examples of having practised it. Saskatchewan, however, appeared to be prepared to take it further, while in Alberta, government would take the lead and often act unilaterally.

Stage 5: Deconstructing the problematic

Stage 5 (chapters 2, 4, and 5) discusses the basic social science issues in light of the case studies and the contemporary debate on how health reforms, for example, the public/private mix in health care delivery and funding, ought to take place. Depending on what knowledge is given legitimacy and primacy to inform public policy, dictates the likely impact on citizen health. The research problem has three subproblems that can be appropriately tackled by the social sciences. What is the relationship between knowledge and health reform and what should it be? How should the demarcation of legitimate knowledge from illegitimate knowledge be determined? What is the relationship of fact and value, and what should it be?

Researchers are frustrated by policy makers and vice versa. What contributes to this gap and perpetuates it? The social sciences can help derive a model or theory that can assist in closing the gap in what appear to be irreconcilable views.

Stage 6: Finding a way forward

Stage 6 (chapters 11 and 12) discusses the applied social science issues with an eye on prescription arising from the research. The theory or model developed in this thesis does two things. It creates a mechanism for bringing scientific facts, values, ideology, and opinions to the policy-making table in an open and explicit way and ensuring that all evidence, whether scientific or values based, is rigorously assessed within their domain. Three models or theories are developed. The first consists of a metaphor for a policy-making process that comprises best practice in policy making and research, linkages, accommodation, and traction. The second is the STEEPLE model that provides a framework of how to bring the social sciences in to help inform the policy debate. The third is a series of best practices identified as a starting point for discussion in the policy-making, knowledge transfer, and research communities to advance the policy-making process outside of its current stalemate.

The thesis concludes with several reflections on the models, including their weaknesses and strengths. Ideas for further research in health care policy making are put forward.

Chapter Two

Reframing the public policy problem: Knowledge and health care reform

Introduction: Why the problem needs to be reframed

The purpose of this chapter is to reframe the public policy problem, the major research problem, and the three major subproblems introduced in chapter 1. Reframing of the public policy problem is necessary because contemporary approaches appear to be mired in perspectives that perpetuate an inability for policy actors and researchers to work together effectively and to introduce fresh and innovative solutions. By definition, *reform* demands an abandonment of at least some of the imperfections in society. This inability for adaptation has led to a stalemate in capturing opportunities for the uptake of new forms of knowledge, as well as in identifying, developing, and adopting best practice in policy making. Three subproblems comprise the research problematic: the relationship between knowledge and health reform, the nature of legitimate knowledge, and the relationship between fact and value. This research problematic has challenged policy actors and researchers with (a) unclear understandings about the nature and relationship between knowledge and reality; (b) weak identifications and communication to the policy community about legitimate forms of knowledge that could or should inform policy questions; and (c) poor explications about the relationship between facts and values that are closely related to values discourses, politics, and power. The views of the four epistemic communities discussed here as to what comprises legitimate knowledge and how one differentiates between facts and values leads to a dissonance (contradiction) in the policy discourse both at a normative and at a prescriptive level and has led to disagreement on how to move forward. This chapter begins to unravel these three problematics by looking at the work of Archer (2000), who has provided a nuanced description and analysis of different forms of knowledge: embodied, practical, and discursive.

As noted earlier, in addition to empirical questions, there are two other perspectives on the three subproblems identified. One is normative (e.g., values, ethics, politics) and the other is prescriptive (e.g., What should or could be done?). From the interplay of the empirical and the normative and between the theoretical and practical, a syncretic redefinition emerges in an attempt to reconcile contradictions. The normative perspective is captured at the representational level of the analysis and is described in chapter 1. Here I point out that policy actors should do something to break the stalemate and a good way to do it is through better knowledge (HQE). In evaluating the empirical comparative case studies in light of this normative commitment, I formulated my prescriptions in chapters 11 and 12. My final conclusions were derived from a synthesis of the representational and critical levels of analyses. More simply, in Archer's words, the thesis undertakes a "syncretic redefinition" of the problematic to reconcile the "constraining and competitive contradictions" that arose from the conflicting perspectives of the four epistemic communities interviewed.

More specifically, my normative perspectives are induced from the GT approach of the case studies (chapter 3 and chapters 7 to 10), as well as from the narrative histories (chapter 6). The critical level of analysis includes the social and political theorizing in chapter 5, and the epistemic issues are problematized in chapter 4. Table 1 illustrates the analytical structure of the thesis that adds depth to the empirical analysis of the case studies.

Table 1: Research Perspective, Type of Analysis, Approach, and Chapter

Perspective	Type of analysis	Research approach	Chapter
Syncretic redefinition	Reconcile contradictions	Reframing the public policy problem	2
Normative	Representational level of analysis	Grounded theory	3
		Narrative histories	6
		Case studies	7 – 10
Prescriptive	Critical level of analysis	Epistemic issues: problematizing knowledge	4
		Social and political theorizing	5
Metatheoretical	Metareflexivity	Theorizing and model building	11 – 12

Although my research optimistically identified the potential for improving relationships between the four epistemic communities and advancing the use of a broad scope of knowledge to inform policy making, I found the complications and complexities less straightforward than I had first assumed. What emerged in the research process was my own evolving understanding of a very complicated matter that implicated knowledge in questions of legitimacy, values, politics, and power (not only practical knowledge, but also scientific knowledge). It is important to add a cautionary note: even though I had to assume it for the study to proceed, no one has yet demonstrated that high-quality scientific evidence (HQE) is necessary for good health care policy making – at this point this is an outcome to be proven, not presumed. Nevertheless, another caution is important. In light of this absence of absolute confirmation, it does not follow that the insufficiency of HQE for good policy making justifies its opposite: the promotion of ignorance or error. Although HQE may be insufficient, this does not make HQE unnecessary – it is necessary, and common sense should tell us that much. But what is HQE? That is a more complicated matter, which is also addressed here.

How to reframe the public policy problem?

The chapter begins with a description and analysis of Archer's (2000) treatment of forms of knowledge and relationships among them. Archer's dictum that "practice is prime" provides a clue as to why dissonance emerges between the creators of new knowledge and those who are expected to use it. Practical forms of knowledge (practice) differ among epistemic communities and each community's perception that it has a hold on the "truth" means that, without effective ways of engaging in discourse to mitigate the differences, the knowledge-to-praxis gap is perpetuated.

This gap leads to a need to review the policy-making literature with a view to establishing a normative and theoretical understanding of the development, weaknesses, and strengths of that literature in order to advance in a practical sense what best practice in policy making might look like. I review a selected literature on knowledge transfer, particularly as it relates to health care policy making, and I note the barriers and facilitators to knowledge transfer. The use of scientific evidence from the health sciences literature to inform policy questions is established as being reasonably well understood. What is not understood, however, is how the evidence in respect to the values and ideology surrounding a health care policy issue ought to be used. Two Canadian researchers tackled the exposition of ideology and values and how they relate to policy making. Gibbins and Youngman (1996) provide a model of how to think about the dimensions of political ideology and what they mean for the state and the individual citizen. Giacomini, Hurley, Gold, Smith, and Abelson (2001), on the other hand, provide a tool for how to identify and think about values of individuals, communities, and society. Although the tools have not been validated in the practice setting, they provide a way forward for reframing the policy problematic, with values and ideology as part of the policy solution rather than as the problem. The chapter concludes with the observation that policy making that depends on traditional scientific evidence lacks some important knowledge to inform policy making. What follows from this insight is that introducing mechanisms to facilitate values and ideology along with traditional scientific evidence at the policy-making table may be necessary.

Reality and forms of knowledge

The issues surrounding the questions of "What is reality?" and "What forms of knowledge best represent it?" have a long tradition in ontology and epistemology. These issues will not be addressed or resolved in this thesis, other than the earlier brief discussion of epistemic issues relevant to this thesis. What will advance the argument of this thesis, however, is an examination of the selected work of Margaret Archer (2000) surrounding three forms of knowledge: embodied, practical, and discursive.

Table 2 is an adapted tabular representation of Archer's Venn diagrams of the three orders of reality, attendant forms of knowledge, where and how they are situated, and the relations between and among them.

Table 2: Archer's Three Orders of Reality and Their Respective Forms of Knowledge

NATURAL ORDER	PRACTICAL ORDER	SOCIAL ORDER
Embodied knowledge	Practical knowledge	Discursive knowledge
Nature	Material culture	Propositional culture
Natural relations	Practical relations	Discursive relations

Note. From (Archer, 2000, pp. 154 - 190)).

The tabulation of Archer's model into cells that are discrete is problematic because it gives the impression that they are isolated and static, and this is far from the case. The relationships among the cells should be seen and understood as permeable, dynamic, and iterative at all levels; however, this simplified adaptation will serve us later as we think about different forms of knowledge of politicians, policy makers, researchers, and citizen elites.

Archer (2000) divides reality into nature, a material culture, and propositional culture. The categories accompanying nature are natural relations and embodied knowledge. Of embodied knowledge, Archer states, "it is based upon sensory-motor interactions with nature (both animate and inanimate); it is possessed in unawareness of its cognitive content, which is not disentangled from physical operations; it can only be exercised in direct contact with nature, and is never detached from it in the form of abstract and decontextualized propositions" (Archer, 2000, p. 162). We think of embodied knowledge as being "second nature" and "knowing how" while we are doing. Natural relations manifest in forms of human posture in nature. Misuse of embodied knowledge is biologically regulative – if we stub our toe on crossing a threshold that stubbornly gets in our way, eventually we raise our foot higher without "thinking" about it.

The abstract attitude arises in individuals from embodied knowledge, leading to a reflexivity that in turn gives birth to material culture, which in turn gives rise to practical knowledge. Practical relations arise as a necessity to sustain the practical order. Archer (2000) identifies four characteristics of practical knowledge:

1. Involves actively doing – procedural rather than declarative
2. Involves performing a skill – implicitly
3. Involves an activity – conducted tacitly
4. Involves extending the body – through extension

Embodied knowledge arises from self-discovery, whereas practical knowledge comes with apprenticeship. The relation between these two categories gives rise to a rich socio-cultural reality. Our proclivity toward embodied knowledge manifests itself when we "fiddle" with a remote control to turn on a DVD player rather than resort to the instruction manual.

Practical knowledge has its enablers but it also has its constraints. It is enabling in that it magnifies the human body's influence on nature through extension; the constraint is that not all of the influence is good. The translation of practical knowledge and skills of a harpist into discursive knowledge is a challenge. Perfecting a golf swing through instructional videos (a form of discursive knowledge) is helpful, but "getting" it is a matter of practised skill. Where descriptive language is incapable of transmitting the procedural steps of performing an act with connoisseurship, it remains silent. Archer (2000) warns us, however, not to collapse a subject's embeddedness in their practical skill into a conflation of the subject and the object. Archer emphasizes, "analytical dualism insists that there are independent properties of subject and object, some of which are entirely irrelevant to the activity and others which are conditions for the very possibility of practice" (Archer, 2000, p. 172). This is important because it sets the conditions of communication and relations between the practical and discursive forms of knowledge.

In the social order, the analytical dualism between the knowledge base that comprises the propositional culture and the discursive relations among the people and their resulting iterative interaction is what leads to further development of discursive knowledge. Archer (2000) makes an important distinction of the logical relations between components of the cultural system (CS) and the causal relations that maintain Socio-Culturally (S-C) between the different groups of the intellectual elite. Practically, this means that CS has an autonomous and objective existence and relations among its beliefs, values, theories, and premises. CS is a product of socio-historico-cultural interactions that in its emergence manifests its own properties that, in turn, influence discursive relations among the S-C actors. The CS exerts causal influences on the S-C level.

Emerging from these logical relationships and causal linkages of CS and S-C are ideas that may be in contradiction or may be complementarity to one another. From these tensions arise discursive relations that emerge as new discursive knowledge. A constraining contradiction can lead to acquiescence by someone who may disagree with the idea but is victim to a circumstance where they must accept it as a result of situational circumstances or logic. If they choose to address the contradiction face on, they must do so by repairing the contradiction through "syncretic redefinitions," which attempt to repair the relationship between the ideas (Archer, 2000, p. 175). Those undertaking syncretic redefinitions do not flee from the contradiction nor do they acquiesce – instead they forge ahead. The situational logic resulting in concomitant complementarity is a win-win situation for the intellectuals – ideas, theories, and models are reinforced, resulting in business as usual and ideational systematization at the CS level (Archer, 2000, p. 175).

Propositional cultures thrive through increased discursive relations and the discursive knowledge grows. Although the discursive relationships are ideational, they also involve material interests. Archer (2000) points out, "Consequently at any given time there may be groups at the S-C level who feel their interests to be ill-served by a given hegemonic CS and who are concerned to advance ideas more conducive to improving their material conditions through their discursive relations. Yet, these too cannot be immune from the existing propositional culture for this is the ideological source of their perceived oppression" (Archer, 2000, pp. 176-177). Unlike the constraining contradiction identified earlier, what arises in this case is a competitive contradiction in which groups prompted by interests attempt to promulgate their ideas over others. These interests attempt to impinge upon the relevant population.

Archer's (2000) argument has relevance for this thesis because it provides a framework by which we can think about and analyze the data from the politicians, policy makers, researchers, and citizens about how they view different forms of knowledge – scientific evidence, values, ideology, and opinions. We will, on closer examination and application of Archer's ideas, illustrate why the chasm between knowledge production and its uptake in policy making is rooted in what the respective communities identify as legitimate knowledge. It also provides a way forward on how to address the constraining and competitive contradictions that arise in the health care reform policy-making process. It is now to an elaboration of the relations among the different forms of knowledge that we turn.

Relations among forms of knowledge

Synergistic results arise through communication among embodied, practical, and discursive knowledge resulting in accreted value at the nexus of each transaction. This thesis attempts to reframe the communication among the different forms of knowledge with a view to providing a fresh way forward for more effective health care reform policy making. The three different forms of knowledge have different human interests vested in them and the resulting relations between and among them are products of those investments. An example from the health care system can be characterized by three forms of knowledge in nursing: empathy is a form of embodied knowledge, whereas inserting a catheter into the bladder is a form of practical knowledge and deducing a diagnosis from a patient history is a form of discursive knowledge. Archer (2000) illustrates the relations between embodied, practical, and discursive knowledge through an illustration showing that embodied knowledge moves to practical knowledge through demonstration (e.g., nurses watching other nurses expressing empathy to a patient "learn" empathy). The transfer from discursive to practical is through application: learning about the anatomy of the urethra and bladder and practising threading the catheter. Practical knowledge moves to discursive knowledge through metaphor: threading a catheter is like "threading a needle." Practical knowledge moves to embodied knowledge through incorporation: threading a catheter "blindfolded." The list is not exhaustive or mutually exclusive but it provides an insight into the major ways that knowledge is transmitted and translated between modes. Central to Archer's argument is that practical knowledge has primacy over the other two: "…practice is truly pivotal because of the role that material culture plays as a 'translation medium' which, through 'technology', enables theory to be the growing point of practice, and which, by virtue of 'instrumentation' enables the codified diffusion of future embodied knowledge" (Archer, 2000, pp. 178 - 179).

Epistemic communities and knowledge

In examining epistemic communities, Miller and Fox (2001) observe, "Past experience and tradition have a greater hold on us than most decision models, policy models, and research protocols allow" (Miller & Fox, 2001, p. 678). The practical utility of Archer's (2000) description of the forms of transmission between the three forms of knowledge is that it forces us to think about the forms of knowledge exchange that take place among the four epistemic communities: politicians, policy makers, researchers, and citizens. If politicians are responding to an issue in the legislature that requires an expression or response from embodied and practical knowledge and researchers are responding with discursive knowledge, there is not likely to be much resonance for problem solving without significant translation having occurred in the process. On the other hand, when policy makers state that researchers are isolated in ivory towers, they fail to see how discursive knowledge can come to the aid of their practical problems. In order to set the context for thinking about different forms of knowledge and how they might be facilitated among the epistemic communities, see Table 3.

Table 3: Types of Knowledge by Epistemic Community

	EMBODIED KNOWLEDGE	PRACTICAL KNOWLEDGE	DISCURSIVE KNOWLEDGE
Politician			
Policy maker			
Researcher			
Citizen elite			

In conclusion, the final lesson taken from Archer's (2000) work is her assessed primacy of the practical form of knowledge. This in itself is a contested concept and will not be addressed in this project, but my experience of over two decades in the health care system signals to me that practical knowledge of health care professionals has a very established place in society. If practice is as intransigent as it is, a question then arises: "What is best practice and how does one encourage it in the provision of care, delivery of services, and public policy to organize and fund best practice?" One could accept that it is possible to describe best practice at the bedside, in the hospital, or at the boardroom table. What would best practice at the policy-making level look like? Having raised these questions for treatment later in the thesis, I now turn attention to some of the practical issues of health services research (HSR) and health care policy making.

Understanding policy making: A brief historical perspective

How are we to understand the policy development process? Howlett (2002) provides us with one synthesis of how the policy-making process has been described and analyzed based on a historical overview of the sentinel policy development literature (Howlett, 2002). Howlett begins with Lasswell, who advanced policy science when he first characterized the following items as comprising the policy development process:

- Intelligence gathering – collection, processing, and dissemination of information to participants in the policy development
- Promotion of particular options

- Decision makers choose a course of action
- Course of action is implemented with sanctions identified for those who do not comply
- Results evaluated relative to the goals established

Although the model was simple, it made a significant contribution to the policy sciences in that it extended the policy process beyond that of government and was characterized as an iterative process (Howlett, 2002, pp. 174 - 175).

During the 1960s and 1970s, studies in the policy sciences resulted in several "schools" of policy development (Howlett, 2002). The pure rational model arose from studies that showed policy makers following systematic methods for arriving at logical, linear, efficient, and effective policies. Policy makers were characterized as neutral technocrats, identifying a problem and then finding the most effective or efficient way of solving it. This model was soon brought into question as experience with policy making showed that it was hardly a linear affair. Recognizing the weaknesses of this approach, Lindblom introduced the limited rationality model (incremental model). Lindblom discovered that policy makers often had vested interests or were not competent to deal with the issues as a result of the unavoidable complexity of the policy-making process. This led to the following characteristics of policy making.

- Analysis was limited to a few somewhat familiar policy alternatives differing only marginally from the status quo.
- Analyses of policy goals were intertwined with other values and the empirical aspects of the problem.
- A greater analytical preoccupation with the problems to be remedied than positive goals to be sought.
- A sequence of trials, errors, and revised trials.
- Analysis that explores only some, not all, of the important possible consequences of a considered alternative.
- Fragmentation of analytical work to many vested participants in policy making. (Howlett, 2002, pp. 174 - 175)

Lindblom identified that bureaucrats found it difficult to redistribute resources from the existing pattern of distribution (status quo), creating an inherent characteristic of bureaucracies maintaining the status quo.

A second critic of the rational model of policy making was Simon. Simon, like Lindblom, identified several elements that worked against rational policy making:

- Cognitive limitation of decision maker to consider all possible options
- Inability to foresee all consequences of a policy decision
- Comparisons of benefits and consequences are often incommensurate
- Unambiguous conclusions as to which alternatives are superior may not be possible (Howlett, 2002, p. 175)

This characterization of the "unmanageability" of the policy process led Simon to coin the "satisfycing" criterion, which, given the "bounded rationality" of people, led decision makers to satisfy whatever criteria they set for themselves (Howlett, 2002, p. 175).

Howlett (2002) draws attention to the work of March and Olsen (1979, as cited in Howlett, 2002), who asserted that public policy making was inherently an irrational process. They named their model the "garbage can" model[1] of decision making, asserting that the rational and incremental approaches implied a greater level of intention, comprehension of problems, and predictability of relations among actors than they found in reality (Howlett, 2002, pp. 175 - 176).

Each of the approaches identified earlier has been strongly criticized by subsequent theorists and policy scientists. Experience began to demonstrate that there was an element of truth in many of the models that characterized the policy-making process – however, none of them explained policy making entirely. This led Lindblom and Cohen to illustrate the policy-making approaches as ranging from the proactive synoptic at one end of the spectrum through to disjointed incrementalism in the middle and ending with the blundering reactive state at the other end (Howlett, 2002). Emerging from this approach was the recognition that there were different policy styles that were prevalent at each stage of the policy development processes, for example, the work of Howlett and Ramesh (2003) and Pal (2001). The summary of the literature makes it hard to fathom that the introduction of best practice in health care policy making is even remotely possible, which makes it all the more important that this project establish a foundation for what those practices might look like.

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[1] March and Olsen coined the name of their model with the specific intention of removing any mystique of science or rationality implied by earlier theorists.

Role of research and policy making

Good evidence is necessary for good policy making, but it is often not sufficient. A paradox, however, has been noted with the observation that research is "not used" to inform policy making, but "If it is not used, why do we produce so much of it?" (Shulock, 1999, p. 226). How are we to define HSR, research evidence, or HQE? One writer states that the purpose of HSR is to "produce reliable and valid research data on which to base appropriate, effective, cost effective, efficient and acceptable health services" (Bowling, 1997, p. 5). HSR

> is applied research that relies on a multitude of disciplines to inform questions on health services and systems. HSR relies on a positivistic scientific method for acquiring information that can be used for reasoned decision making in the management of health and the health system. HSR is ultimately concerned with improving the health of a community by enhancing the efficiency and effectiveness of the health system as part of the overall process of socioeconomic development. The perspective of health services research is the broad societal or population perspective not the individual perspective. (Fulop, Allen, Clarke, & Black, 2003, p. 155)

Why do we want to privilege the position of high-quality HSR in respect to policy making? The perspective of one leading thinker in the field of knowledge utilization in policy making states:

> It is assumed that research exposes policy-making to a wider range of validated concepts and experiences than those that can be drawn from the normal time-limited and politically constrained process of policy deliberation. It thus allows a broader choice of public policy options to emerge. Research often enables policies to be generated upon technically well-informed bases. It gives warnings of reasons why some policies succeed and others fail. It can make connections between otherwise separate factors such as the nature of the substantive field and organizational patterns set up to manage them, or the power of environments over health outcomes. It legitimises some policies and throws legitimate doubts on others. (Hanney, Gonzalez-Block, Buxton, & Kogan, 2003, p. 5)

What constitutes HSR has been changing through the entry of new fields of study into its domain. Originally HSR was dominated by systems analysis, demography, operations research, epidemiology, finance, and health economics. HSR now looks to sociology, political science, health law, informatics, organizational science, nursing and other allied health science perspectives, cognitive science, anthropology, and ethics, to name a few. Practical knowledge from these fields is migrating into the discursive knowledge of the health care system, while discursive knowledge is making an impact on the practical knowledge.

Knowledge transfer strategies

Dobbins, DeCorby, and Twiddy (2004) describe a knowledge transfer strategy that they explored with public health decision makers. Dobbins et al. sought their advice about how to structure a comprehensive national public health knowledge transfer strategy. The results of the focus groups were that they

> supported the development of a registry of reviews evaluating the effectiveness of public health interventions rated by methodological quality of the evidence…with a summary…with implications for practice…participants wanted to receive personalized updates of new reviews along with specific implications for practice…and interest. Finally, the results highlighted a significant challenge related to knowledge management indicating opportunities for ongoing professional development and training. (Dobbins, DeCorby, & Twiddy, 2004, pp. 125-126)

There are several lessons from Dobbins et al.'s work, but the most daunting perhaps is the magnitude of the challenge to establish and effectively manage the knowledge acquisition, assessment, and review systems to inform the myriad of health care issues arising.

It may be that good-quality research introduces a solid foundation of knowledge for policy making; however, governments may not be patient enough to wait for the knowledge to be created or synthesized. A warning is sounded by Sabatier (1986) on the time it may take to see results of programs: "In assessing the effectiveness of various attempts at guidance and control, one needs to take into account a reasonably long time-period, at least 5 – 10 years. Shorter time frames may produce quite erroneous conclusions" (Sabatier, 1986, p. 322). Bringing in knowledge to inform policy may create complexity and time delays in policy making. John Maynard Keynes, who had experience working in government, was noted to have said "there is nothing that a Government hates more than to be well-informed; for it makes the process of arriving at decisions much more complicated and difficult" (Skidelsky, 1980, p. 630). Using high-quality scientific evidence to inform policy may be undesirable as well, in that it limits what a government may "wish to do." If evidence suggests a course of action that is contrary to the ideological orientation of the party in power, the party may find it difficult to reconcile its actions to a public about promises made in an election platform. These objections to the use of scientific evidence cannot be ignored if we are to understand how to improve its effective uptake.

In a case study examining the review of the use of evidence to inform explicit priority setting in New Zealand, Tenbensel (2004) found that "…efforts to gather more policy-relevant evidence, in themselves, are unlikely to lead to policy making that is more rational and less political" (Tenbensel, 2004, p. 204). Tenbensel recounts that the problem was not a matter of acquiring the evidence. The difficulty came from having to deal with divergent implications arising from the evidence. This insight is important because complementary forms of evidence from the social sciences are a necessary prerequisite for informing health policy making. The weakness pointed out by Tenbensel flags the need to develop competent core activities within the policy-making settings, which are able to respond to the uncertainty that arises from divergent forms of evidence.

It may be helpful to differentiate among the ways in which research evidence can be used to inform policy makers. Black (2001) points out that research evidence can be used to inform three categories of policy: governance policy, service policies, and practice policies (Black, 2001, p. 275). Lomas (1990) proposes a similar nomenclature – legislative, administrative, and clinical categories of policy (Lomas, 1990, p. 542). These categories can be seen along a spectrum and it is "generally agreed that research has least impact on the first of these categories and most on the third where often the relevant knowledge comes from clinical research" (Hanney et al., 2003, p. 7). The biomedical science model has a greater chance of influencing policy making at a clinical level than does a solid piece of ethnographic research that may inform a question on the impact of type II diabetes on a first nation's community. This has created a paradoxical circumstance. Policy makers who have been encouraging those in clinical practice to use evidence to inform their practice are now being encouraged to apply the principles of evidence-based decision making (EBDM) to decision and policy making at the administrative and legislative levels (Ham, Hunter, & Robinson, 1995, p. 71). Using Archer's (2000) argument, the policy community that was encouraging the health practice community to improve its practice through adoption of discursive knowledge now has the table turned on it by insisting the policy community begin to take more seriously the discursive knowledge arising from health practice. This project will attempt to unpack how this has arisen and explain how the respective epistemic communities perceive the role of knowledge in health care policy making. In chapters 10 and 11, I show how best practice can be developed and established in policy making with actions taken to ameliorate this weakness in contemporary policy making in health care.

The gap between research and policy making

Why is there a gap between what evidence should be used to inform policy and what is being done? Stocking (1995) in a commentary on why research findings are not used by commissions in the United Kingdom, identifies four reasons: "(1) the research is not there; (2) many managers are not 'knowledgeable'; (3) public health (and others) does not act as a product champion of knowledge; (4) change is more difficult than expected" (Stocking, 1995, p. 380). Stocking's experience is in the United Kingdom, but this literature review supports her assertions for Canada.

In the Canadian context, Lomas, the current president of the Canadian Health Services Research Foundation (CHSRF), provides us with significant insights as to why research evidence falls short of informing policy making. Lomas (1997) identifies four misunderstandings between the evidence production effort – research – and the policy-making effort. His first point is that researchers and policy makers consider each other's activity as generating products instead of engaging in processes – in other words, policy makers think of research or HQE as something that can be picked off a shelf, like a carton of milk at the grocer. Second, researchers tend to not appreciate the distinction of a rational decision that is research driven and context free and a sensible decision that is pragmatically driven. Scientific research attempts to focus the question so that a clear and crisp answer can be provided. Policy making, on the other hand, tends to take other variables such as interests, ideology, values, or opinions into account. Third, decision makers are not sensitive to the incentives that drive researchers. Academic researchers receive their rewards by attracting grant money, discovery, publishing in peer-reviewed journals, and adding to the length of their curriculum vitae, rather than responding to a current issue before the Minister of Health. Fourth, researchers rarely take into account the different audiences that would be audiences for their research. The culture in the research community is generally one of academic rigor that is measured by the complexity and nuance of language as well as ideas, and not its transparency and parsimony. The policy community has multiple audiences of differing levels of sophistication – multiple types of messages must be customized to their needs (Lomas, 1997). The CHSRF has recommended a guide for health researchers in the dissemination of research findings: their products should consist of a 1-page summary, a 3-page executive summary, and a 25-page report. The 1-page summary is for the politician, member of the public, or Deputy Minister; the 3-page summary for a Deputy Minister or bureaucrat; and the 25-page summary for another researcher. These four misunderstandings in the cultures of the two epistemic communities and their lack of appreciation for one another contribute to the chasm between them.

Although not specifically focused on health care policy making, a project undertaken by Landry, Lamari, and Amara (2003) provides some useful insights into the extent and determinants of utilization of university research in government agencies. Landry et al. (2003) conducted a survey of 833 government officials in seven policy domains at the national and provincial levels; their definition of use of research was extended to include all stages of the policy-making cycle. The results from Landry et al.'s (2003) work are mixed; some of the relevant results for this project are "research projects focused on users' needs were not more likely to lead to utilization than projects focused on the advancement of scholarly knowledge" (Landry, Lamari, & Amara, 2003, p. 203). This finding was astonishing, as most research work noted that a closer connection between user and researcher would be a positive predictor of utilization. It may be possible that the characteristics of the health policy field are somewhat more reliant on the user-researcher connection and this was not captured in the aggregate of Landry et al.'s project. A second finding of relevance was that knowledge utilization could be increased by introducing incentives targeting adaptation of research products and acquisition efforts (Landry et al., 2003, p. 203). This finding confirms the observation that structuring appropriate incentives to the producers and receptors of research can be an effective means of improving uptake. The study also showed that linkage mechanisms were good predictors in all but one policy domain. In conclusion, the authors state:

> … utilization of university research in government agencies is far more complex than is predicted by the existing theories, and it is influenced by contingent factors that will be difficult to integrate into a comprehensive theory of knowledge utilization. Therefore, additional theoretical is needed to refine the exiting theories of knowledge utilization and, likewise, more empirical studies are needed to better identify the factors explaining the uptake of university research in diverse categories of government agencies and policy domains. (Landry et al., 2003, p. 203)

Landry et al.'s (2003) observations resonate for this project and are further justification for undertaking an examination of the factors that may affect the uptake of research findings.

The use of research to inform policy

Recognizing that there is likely a wide range of contexts, from hostile to researcher friendly settings, that policy makers function in, what might be a range of the possible uses of research to inform policy? Hanney et al. (2003) conducted a detailed study of the trajectory of research and its influence or effect on health care policy. Table 4, extracted from the work of Hanney et al., is illustrative of how research is used.

Table 4: Decision Context, Research Inputs, and Forms of Research Utilization in Policy Making

		CONTEXT OF DECISIONS			
		Explicit		Implicit	
		Choice		Support	
		Technical ↓	Political ↓	↓	↓
RESEARCH INPUT	Models →	Conceptual modeling	Constrained frameworks	Symbolic payback	Paradigms
	Specific findings →	Data-based policy	Strategic research	Symbolic argumentation	Practice wisdom

Note. From (Hanney et al., 2003, p. 9)).

The context of decisions can be described as explicit and specific or implicit and diffuse. They are explicit if they are open and transparent to the public and implicit if they are conducted behind closed doors. If they are implicit, they are more likely to be informed by the paradigms or common practices, which require a minimum, if any, formal research. Decisions that are explicit and open to public view are likely to require some form of research to support the choice taken. Traditionally, political decisions tend to be justified in terms of values or ideology shaped in the political arena. Scientific efforts are often helpful in providing support of policy formulation – but often in reverse – providing justification for a policy action taken. Technical decisions are often justified in respect to the scientific enterprise. In the context of this study, explicit decision making, with choice-based technical approaches and conceptual modeling, supported by clean data, would be synonymous with best practice. The model in Table 4 is characterized by discrete cells but in reality the elements are known to be part of a continuum, not mutually exclusive, and they intermesh rather than exist in isolation. According to Hanney et al. (2003), the use of research in "policy making should eventually lead to desired outcomes, including health gains" (Hanney et al., 2003, p. 23).

In addition to the specific studies undertaken and noted on the research-to-policy-making gap, Hanney et al. (2003) conducted a comprehensive and systematic review of the literature on the utilization of health research in health care policy and identified six models of knowledge utilization:

- The classic/purist/knowledge-driven model – knowledge is created, informing policy that impels action
- The problem-solving/engineering/policy-driven model – a question arises from a client, stimulating a linear sequence of activities from problem identification to development and assessment of alternative solutions
- The interactive/social interaction model – researchers and users share a common world in which the interactions result in creation of evidence
- The enlightenment/percolation/limestone model – research is seen as an accumulation of insight, theories, concepts, and perspectives
- The political model – research is motivated toward and provides ammunition in a contested environment of policy making
- The tactical model – if in doubt about next steps in policymaking, commission a research study. Perceived as a delaying tactic or a way of avoiding the issue, this can be a helpful technique (Hanney et al., 2003, p. 8)

Hanney et al. characterize knowledge utilization along a continuum. This nomenclature is helpful, but, with the exception of the first three models, it alone does not provide a way forward for how to respond effectively with best practice in policy making with HQE in the different settings. An awareness of the different models does, however, inform the research community in understanding the motivation for the chasm in the research-to-policy gap.

Merging knowledge transfer and knowledge utilization

Archer's (2002) concepts of embodied, practical, and discursive knowledge can be combined with the work of Hanney et al. (2003). Embodied knowledge is situated at the implicit end of the continuum, practical knowledge commandeering the middle ground, and discursive knowledge – the more intellectually challenging source of information – at the technical end.

Taking the lead from Hanney et al. (2003) and Archer (2000), it would appear that best practice in policy making, coupled with achieving the best ends for improved population health, is more likely to be created from the technical category in which conceptual modeling and data based policy are produced from accurate knowledge of health challenges. Individual and population health are far too complex and important to be left to the whim of a misinformed ideology or a mean spirited value. Rather, they require the rigours of due diligence and robust data that can be trusted to inform policy making.

Work in comparative international health care reform can provide us with some further insights into what a difficult area of public policy this is. In the preface of one comparative work, the editors remark on the experience of four countries. They state:

> In each of them, progress toward universal coverage was quite gradual, and each has continued to alter its structures and procedures to meet emerging circumstances. Their experience shows that the road to universally assured access to care is winding and often tortuous and that when this objective has been met, new and unforeseen obstacles appear. The journey of health care policymaking is not made without struggle and is not marked by clear signposts. The developments of an effective and equitable health care system is arduous and never finalized, but it is one that nations undertake out of fear of a greater failure. (Powell & Wessen, 1999, p. x)

Implications for Alberta and Saskatchewan

It is the spirit of attempting to uncover whether the health care reform policy process in Alberta and Saskatchewan was reliant on certain preconceived notions or on rigorous scientific evidence that is the interest of this project. If policy making is found wanting, based on arbitrary and inconsistent action relative to HQE, then how might this be improved? Other influences such as values, ideology, and opinions and how they entered the discourse along with HQE is a primary interest of this study. Did the epistemic communities recognize that, in the process of problem identification and definition leading to the development of alternative policy solutions, they were "steering" the alternatives considered as solutions through the use of their techniques and methods? Were the members of the four epistemic communities aware of the difference between and among the four types of ideas circulating around issues of health reform? If they were, how did they differentiate among them and were they able to rate the merit of the values, ideology, and opinions as compared with the evidence? The research and analysis of this thesis attempts to supply answers to these questions.

Scientific evidence and its use in policy making

What is the scientific evidence that might help inform the earlier question of how health care policy makers use scientific evidence to inform their policy questions? Responses to filling the gap between researchers and policy makers have arisen from the producer (push) and user (pull) models of knowledge transfer and uptake. These models have been supplemented by the interaction model of knowledge transfer and uptake (Landry, Amara, & Lamari, 2001). Sabatier (1986) observes:

> …an important factor affecting the extent of policy-oriented learning seems to be the existence of reasonably well-structured communication …in which professionals and other experts from different advocacy coalitions are forced to confront each other's arguments in a relatively depoliticised setting. Thus, despite the partisan nature of policy making and severe cognitive limits on rationality, actors' desires to realize core values in a world of limited resources provide strong incentives to learn more about the magnitude of salient problems, the factors affecting them, and the consequences of policy alternatives. (Sabatier, 1986, p. 323)

Lavis et al. (2002) conducted a study of the role of HSR in Ontario and Saskatchewan in which they studied whether, how, and under what circumstances HSR affects provincial policy making. From the traditional political science literature, Lavis et al. (2002) identified three categories of influences on the policy-making process: ideas, interests, and institutions. Ideas include research or HQE, while interests are the perceptions of actors of who will or will not benefit. Institutions are factors such as policy history, time pressures, and level of approval. Lavis et al. (2002) found that the following factors favoured the use of research utilization: citable research, other forms of information (e.g., results of pilot tests), and the policy makers themselves, particularly when they could pursue multiple objectives. Government interests and legacy policies were also factors. Stakeholders pursuing interests were an important influence as well. My study will build on the insights of Lavis et al. (2002) and deconstruct the category of ideas into several dimensions (HQE, values, ideology, and opinions) to provide a deeper understanding of how each may interact with and influence policy making.

Lavis et al. (2002) confirmed the importance of the interaction between researchers and policy makers and the identification of an accountable "receptor" function in government departments, as specified by Lomas (1997) in the use of HSR or other information. Customizing research responses to policy maker's needs was also identified as an important enabler. Other salient findings of the study were that just because a policy did not use research did not mean it was not well informed and that a poorly informed policy can use good research, leading researchers to discriminate between informed policies and those that are evidence based. In their concluding remarks, Lavis et al. (2002) state, "We need to look at more than the use (versus non-use) of research in isolated policy decisions and, ideally, at the way in which research is used and at its use in the context of other, competing influences on the policy making process" (Lavis et al., 2002, p. 147). This project will examine the competing influences to evidence – ideology, values, and opinions.

Innvaer, Vist, Trommald, and Oxman (2002) corroborated the findings of Lavis et al. (2002) through an extensive systematic review of current literature:

> Interview studies with health policy-makers provide only limited support for commonly held beliefs about facilitators of, and barriers to, their use of evidence, and raise questions about commonsense proposals for improving the use of research for policy decisions. Two-way personal communication, the most common suggestion, may improve the appropriate use of research evidence, but it might also promote selective (inappropriate) use of research evidence. (Innvaer, Vist, Trommald, & Oxman, 2002, p. 239)

Canadian researchers have undertaken serious study of the relationship of the research enterprise and the policy-making process. The mission of the CHSRF is "…to sponsor and promote applied health systems research, to enhance its quality and relevance, and to facilitate its use in evidence-based decision making by policy makers and health system managers" (Innvaer et al., 2002, p. i). In February 1999, the CHSRF organized a national workshop on "Issues in Linkage and Exchange Between Researchers and Decision Makers" and four themes emerged:

- The environment for linkage and exchange between researchers and decision makers should be facilitated through leadership from the research funding agencies.
- The costs of linkage and exchange should be recognized.
- Time needs to be set aside by decision makers to prepare for and receive research for decision making.
- Linkage and exchange infrastructure should be supported through such positions as "knowledge brokers." (Canadian Health Services Research Foundation., 1999, p. 1).

These findings can be used to help identify and embed the necessary linkages, as well as best practices (see Appendix F), for the policy community and the research community.

Relationships and linkages among policy makers, funders, and researchers

The CHSRF published a report describing a comprehensive model that explicated the roles and relationships of the researcher, decision maker, knowledge purveyor, and research funders. The model explains the role of knowledge purveyors and where attention should be paid to improve the links between each of the groups (Canadian Health Services Research Foundation., 2000, pp. 4-7). Three suggestions were put forth:

- The process of getting evidence into decision making is more than simple linkage but involves multiple steps.
- Each of the steps involves improving relationships and communication across the four groups.
- Evidence-based decision making is a "virtuous cycle" and a weak link in the chain may interrupt the optimal flow of evidence into decision making. (Canadian Health Services Research Foundation., 2000, p. 7).

These findings will be integrated into the best practices checklist developed for the policy-making and research communities in Appendix F.

Lavis, Farrant, and Stoddart (2001) conducted a study of employment-related healthy public policy in Canada by examining the barriers to the use of information by government departments and nongovernmental organizations (NGOs). Lavis et al.

(2001) looked at three types of barriers: (a) idea-related barriers, (b) institutional-related barriers, and (c) interest-related barriers. The authors made three observations about building on the public policy process. First, health policy makers need to provide leadership in framing information about the health consequences of decisions in terms of the appropriate values and language. Second, health policy makers should advocate for institutional innovations to ensure that health consequences of policy making are not ignored. Third, health policy makers should be prepared to scan and monitor the public, bureaucrats, and stakeholders who may be affected by the lack of support and be prepared to provide them with information (Lavis, Farrant, & Stoddart, 2001, p. 9). These findings will be essential in helping to inform what best practice in health care policy making ought to include.

After data collection and during the writing of this thesis, the challenge of using knowledge and evidence in health care increasingly became a hot topic. A Canadian book was published on the subject (Lemieux-Charles & Champagne, 2004) that brought together knowledge from several disciplinary perspectives. In the postscript to the book, Lomas (2004) states, "Almost every author marks the need to view evidence-based decision making not as a logical or linear extension of science, but as a social process in which the evidence sits alongside or is secondary to personal predilection, professional power, and organizational politics as predictors of outcome" (Lomas, 2004, p. 281). The knowledge accumulating in the disciplines, mostly outside of the quantitative sciences, suggests some useful strategies for bridging between the knowledge modes.

Similarly, in a paper connecting research and policy-making, Bogenschneider, Oleson, Linney, and Mills (2000) reviewed the four theories that have been postulated regarding the utilization of social science research in policy making. Although my project covers a broader span than the transfer and receipt of social science research, Bogenschneider et al.'s review is instructive. The first theory assumed that there is a causal relationship between social science research and policy making. However, the literature reviewed earlier demonstrates *that this is not the case,* as competing factors, such as values, interests, and electablity of politicians, among many others, come into play. The second theory took into account the limitations of the social sciences and caused the social scientists to be reluctant in sharing their findings because of the weaknesses of their methodologies. Nevertheless, more recent social science methods have become more nuanced and sophisticated in the methods they employ, paving the way to greater acceptance. The third theory postulated that social science research is underutilized because the free market democratic forces prevent institutional structures from forming and integrating knowledge and power. This may in fact be true but does not tell us how institutional structures might come together or what they may look like. The final theory, which explains underutilization, is based on a communication gap between the research community and policy makers (Bogenschneider, Oleson, Linney, & Mills, 2000, p. 328). This research explores the nature of this "communication gap" and recommends possible methods for remediation. Bogenschneider et al. focus "on encouraging researchers to be more policy sensitive in an attempt to entice policy makers to be more research sensitive"(Bogenschneider et al., 2000, p. 337). The lessons of this work complement the line of argument developed in my thesis.

Toba Bryant (2002) studied the role of various forms of knowledge in public health and health promotion policy creation. Bryant set out to develop a framework of policy development premised on the fact that public health and health promotion issues ought to be addressed within an analysis of policy change that takes into account concepts of interactive and critical knowledge, along with scientific knowledge. Bryant determined that anecdotal evidence can be a powerful political tool and ideology can influence the types of knowledge and evidence accepted into the political process. In this study, the term "opinions" is used in a parallel sense to anecdotal evidence and practical judgments about "good evidence" and "best practice." She encourages the use of interactive and critical knowledge, along with instrumental knowledge, to advance the policy agenda (Bryant, 2002, p. 97). Bogenschneider et al.'s (2000) and Bryant's works underscore the important role that the social sciences can play in contributing to the policy-making process in health care.

The attention being paid to the issue of increasing knowledge utilization in health care practice, decision making, and policy making is at an all-time zenith. The CHSRF supports the evidence-based management of Canada's health care system by facilitating knowledge transfer and exchange – bridging the gap between research and health care management and policy. The CHSRF does this through several strategic initiatives:

- Identification of research themes through the "listening for direction" canvas of the health care system
- Delivering a series of research granting programs, such as
  - Research, Exchange and Impact for System Support (REISS) Competition
  - Open Grants Competition – applied HSR
  - Commissioned Research – synthesis needs of decision makers
- Providing contemporary information on research in progress
- Publishing the final research reports from CHSRF projects
- Introducing the Knowledge Exchange Yields Success (KEYS) program
- Developing the knowledge exchange and transfer glossary of terms
- Providing a focus for resources in knowledge exchange
- Developing the *mythbusters* series - A series of essays giving the research evidence behind Canadian health care debates
- Introducing CADRE - a partnership between the foundation and the Canadian Institutes of Health Research to develop increased capacity in applied health services and policy research, including nursing management and organization issues
- Introducing the brokering program that links decision makers and researchers, facilitating their interaction so that they are able to better understand each other's goals and professional cultures, influence each other's work, forge new partnerships, and promote the use of research-based evidence in decision making[2]
- Introducing the country-wide fellowship EXTRA program, whose primary goal is to give health system managers across Canada the skills to better use research in their day-to-day work, as a way to increase evidence-based decision making in the health system (Canadian Health Services Research Foundation., 2005).

Building best practice for policy making from the literature

In spite of these and complementary efforts in the provinces with research agencies, a large gap still exists between the evidence and its application at the policy tables. Changing the habits of health system providers, decision makers, and policy makers is a Herculean task and further research into understanding the interactions and gaining the confidence of the policy-making community will be a continuing challenge. As a way of moving forward, Table 5 summarizes the lessons that were applied later in the thesis, along with the findings for this project for building best practice for policy making in health care. It can also be gleaned from the literature that the development of best practice is not an endpoint to be achieved, but rather the continual development and refinement of ideas and practices that will need to be updated as new discursive knowledge arises and practical experience dictates.

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[2] Knowledge-brokering activities include finding the right players to influence research use in decision making, bringing these players together, creating and helping to sustain relationships among them, and helping them to engage in collaborative problem solving. Knowledge brokering in this context is ultimately about increasing evidence-based decision making in the organization, management, and delivery of health services.

Table 5: Extracted Challenges, Lessons of Best Practice from Selected Literature

Author	Implications for potential best practice
Archer (2000)	Practice is prime – therefore lets improve practice Different forms of knowledge require different modes of communication Contradictions require syncretic thinking
Black (2001)	Evidence applies at three levels: governance, service, practice
Lomas (1990)	Evidence applies to legislation, administration, clinical
Stocking (1995)	HSR fails – it's not there, managers don't understand it, it has no champions, change is difficult
Lomas (1997)	Four misunderstandings: research to policy is a process not product, rational and sensible decisions are different, incentives differ for players, and audiences need different products for different audiences
Laswell	Policy making technically rational
Lindblom	Incremental process
Simon	Bounded rationality, satisfycing, benefits and consequences incommensurate, ambiguous solutions
J. Cohen	Garbage can model
Lindblom	There is a continuum, hard to change status quo, values and empirical facts confound alternatives, fragmentation of analytical work
Hanney et al. (2003)	Context of decision is important – move toward data supported, open, explicit, conceptual modelling
Lavis et al. (2001)	Look to ideas, institutions, and interests for barriers and facilitators
Innvaer et al. (2002)	Need for active receptor function and communication
CHSRF	Encourage research funding to build linkages and exchange, cover cost of linkage, decision makers and researchers need to take time and introduce knowledge brokers
Lavis et al. (2002)	Leadership needs to cite consequences of decisions with appropriate values and language; advocate institutional innovation; scan and monitor the public, bureaucrats, and stakeholders for information they may need
Lemieux-Charles & Champagne (2004)	Bring in multidisciplinary perspectives
Bogenschneider et al. (2000)	Use seminars to increase sensitivity of policy makers to researchers and vice versa
Bryant (2002)	Anecdotal evidence is powerful tool – use it as mechanism with support from high-quality evidence

Note. HSR = health services research.

The identification of the different challenges to knowledge utilization underscores the fact that different contexts require specific types and applications of knowledge or research. If all of these models are at work, how can we best understand the circumstances of these so as to improve the likelihood that good evidence will be used? The insights gleaned from the studies provided some guidance as to what questions to put before the four sets of actors – politicians, policy makers, researchers, and citizen elites in Alberta and Saskatchewan – with a view to better understanding what they consider to be HQE; whether they can differentiate among HQE, values, ideology, and opinions; and how we might address the barriers they identify in the effective use of HQE.

Limitations of the models

It is clear that the different models, arguments, and theories of how to advance the use of knowledge are not mutually exclusive nor are they exhaustive. They represent a sample of what research has described as being a useful way of characterizing a complex setting of social interactions and moving forward with improvements to the way decision and policy makers practise. These works have advanced substantially our understanding of the interaction of policy making and the use of research: however, *the gap that exists in the literature is an understanding of how other competing variables such as ideology, values, and opinion play a role in influencing the use of HQE, oftentimes displacing the evidence to the dust bin.* The assumption, until very recently, has been that *if HQE is brought to the table it will be used – which some recent literature has shown is not the case.* Another limitation of the models developed thus far is that *they do not explicitly tackle the issues surrounding the values, ideology, opinions, politics, and power* circulating around the health care policy-making table and invite them into the discussion. The approaches identify ways in which to increase the discourse surrounding the use of HQE, but they do not identify *how to more effectively bring values, ideology, and power into the conversation.* A second concern is whether the creation of a new role in the health care system, the knowledge broker, is the most effective way to close the gap. Some have argued that there is *no substitute for policy and decision makers to cultivate their relationships with those in the academically research based epistemic communities.* This project will demonstrate how explicitly bringing facts, values, ideology, and power to the policy-making table may help to frame policy solutions that are more relevant to the population's health. Most other research has tended to group politicians and policy makers into one category called policy maker – this project separates those out, as it appears as if the needs of the two epistemic communities, although similar in doing the government's work, are in actual fact quite different. This project will attempt to shed some light on this dynamic.

Ideology in policy making

In the perfect positivistic world, facts, values, politics, and power are hermetically sealed from "contaminating" each other and governments would act on the basis of self-evident, high-quality scientific evidence that would be linearly translated into policy. This is not reality; governments make utterly bad policy in spite of the availability of sound evidence because of other influences, such as interests, values, and ideology. Governments may also make good policy on the basis of bad evidence but good values or ideology. Furthermore, sound evidence is a contested concept and divides research communities into cultures of inquiry that form distinctive coalitions around normative solutions to competing philosophies of science represented by positivism, hermeneutics, critical theory, and postmodernism. These philosophies of science lead to competing models of scientific research and practice in the basic, applied, and practical models in the natural and social sciences. Within these models are competing techniques and methods. Not only is good policy contested on the basis of sound knowledge, but "sound knowledge" is also far from a straightforward concept to be merely pulled off the shelf as just another political or cultural commodity (Kachur, 2003).

In examining the role of ideology in policy making, Jary and Jary (2000) define ideology as "any system of ideas underlying and informing social and political action…more particularly, any system of ideas which justifies or legitimates the subordination of one group by another"(Jary & Jary, 2000, p. 286) . This pejorative sense of meaning is opposite to that coined during the French Enlightenment, which was oriented toward an "all-embracing encyclopaedic knowledge, capable of breaking down prejudice and of use in social reform" (Jary et al., 2000, p. 286). In the passage of time since the French

Enlightenment, a definition approximating the pursuit of truth has been reversed to mean the dominance of a set of ideas of one group over another. This in itself is interesting, as the meaning of a word has been transformed in the social context from a positive orientation to a negative sense and then included "scientific" knowledge as a competing knowledge in the pragmatic politics of reform. Contemporary critical theory and poststructuralist versions further characterize scientific knowledge itself as ideological, that is, informed by normative orientations directed at the instrumental or technical control of human subjects as if they were mere objects (Etzkowitz, Webster, & Healey, 1998, pp. 2-17).

This project is committed to the pursuit of small *t* truth in policy making so that it will encourage attention toward ideology in its original sense – that of the pursuit of truth – rather than its more pejorative interpretation today. However, another view of this situation may be to think of the commitment to the pursuit of truth to be an ideology itself, therefore requiring the development of some method to differentiate between what would be good ideology versus poor ideology, just as there is good evidence and poor evidence. Since members of the epistemic communities are socialized to be who they become and who they are, each has a perspective of what the true values, ideology, opinions, and evidence are. "Justified belief, then, is a matter of social practice. Members of the epistemic community share norms (albeit contested and revisable) about how good research should be conducted" (Miller et al., 2001, p. 681). The criteria of what constitutes good ideology in policy making will require further development. However, if ideology involves one group dominating another, certain considerations will need to be taken into account, for example, "Is the domination motivated in the interest of those who are dominating or is it in the public interest?" "How is the public interest defined?" "How does a dominated marginalized group's interest not get subterfuged in the public interest?"

This project argues for a contextual understanding of the evidence, values, ideology, and opinions as they come to bear on public health issues without an automatic predilection for drawing on positivistic methods, inflexible values, or dogmatic ideology. Miller and Fox (2001) state:

> When it comes to methodology and the way we go about inquiry, stepping back (but not abandoning) the old positivism is called for. This means that we who study public affairs should take another look at that set of rules and come to agreement that we cannot mechanically follow the protocol …the notion that we can formulate universal rules for accepting or rejecting a theory is now more nostalgic than useful. Strict adherence to the positivist protocol, which falsely presumes the soundness of correspondence theory, will not produce truer and truer results. Mechanical problems must yield to context. (Miller et al., 2001, p. 682)

Martin Smith (1993) argues that ideology plays a prominent role in policy development: "Ideology defines not only what policy options are available but what problems exist. In other words, it defines the agenda of issues with which the policy community has to deal. Therefore members of a policy community agree on both the range of existing problems and the potential solutions to these problems"(Smith, 1993, p. 62). This characteristic of how one frames problems that impact on solutions in policy making was noted earlier in the thesis.

Thinking about both policy and science as ideology can be characterized in the following three ways:

- Policy is redistributive in its effects.
- Interests are engaged because some will lose and others gain in a policy change.
- There is no neutral policy – it is inherently value laden.

Martin Smith's (1993) view is consonant with those of Osborne (1998) and Scheurich (1994), who advocate a deconstruction or problematizing of the problem statement or issue in a policy question in order to arrive at a politically and/or socially unfettered understanding of it. Seeing policy and science (scientific representations) as ideological can cause one to examine the ideological content of the positions of how actors frame issues, the redistributive implications of how the issues are framed, and how the framing of issues sets the limits. This characterization should cause us to be concerned that the influence of ideology must be very carefully scrutinized and interrogated in order to ensure that its impact on policy is openly and transparently articulated during the policy-making process. It also causes us to think about how one might adjudicate between the interests of the individual, marginalized groups in society, and the greater common good.

Debates of an ideological nature are not only restricted to the realm of politics, but they are also prevalent in the field of academia and research. Debates as to what ought to count as evidence take place among the social sciences, physical sciences, applied sciences, humanities, and technical sciences. The debates centre on issues of internal validity, its explanatory power, the use of unorthodox logic models, and generalizability of the inquiry. Debates also take place within disciplines that are represented by the traditions that are positivist, postpositivist, hermeneutic, critical realist, postmodernist, and poststructuralist. These debates often arise as a result of the corpus of knowledge to which intellectuals subscribe, as well as competition of the fields to attract funds for their respective enterprises. Those that are often seen to be contributing to the further development of the economy are favoured for support in funding for their research project. Those from the other epistemic communities often observe these debates as a sign that the academic community is in disarray, rather than seeing it as a positive characteristic of the syncretic process continuing to develop new knowledge. There is also a trend for ideological commitments to be embedded in the different disciplines, for example, neoliberalism dominating in economics and progressive (social) liberalism dominating in sociology (Kachur, 2004). These ideological commitments appear to wax and wane as the currency of the particular ideological stance reaches a position of primacy or decadence. A deeper understanding of these phenomena by researchers within the academic settings, as well as the policy makers in government, would help to advance a better appreciation of how best practice can take into account differing perspectives and what is legitimized as evidence.

Policy as ideology in British Columbia 1993 - 1996

One study of the relationship between policy and ideology in Canadian health care was identified. Davidson (1999) illustrated the power of ideology in policy making in his examination of health reform in British Columbia during the 1990s using a policy-as-ideology approach. His study demonstrates that the persistence of structural power relations within the health care sector caused the health reform initiative to fail. Factors identified as contributing to the failure were (a) the government being unable to impose controls over health care providers or professionals, (b) failure of government to improve accountability of the programs to the public, (c) failure of government to affect a reallocation of resources in the health sector, and (d) failure of government to shift the policy focus from the delivery of health care services to the community health perspective. These failures corroborate Archer's (2000) observation that practice is prime. Two successes could be attributed to the reform initiative: strengthening administrative arrangements and improving technical efficiency in the provincial health system (Davidson, 1999). Eliminating hospital boards and replacing them with regional health authorities to contain costs can be attributed to the political will of government. To explicate the role of ideology for the actors in his policy analysis, Davidson identified six characteristics of the actor's frame of reference that should be interrogated through empirical research. Deconstructing and interrogating a policy issue around these points will help to set a best practice on how to approach and make transparent and explicit ideology in policy making.

Davidson's (1999) model for problematizing ideology in policy making is as follows:

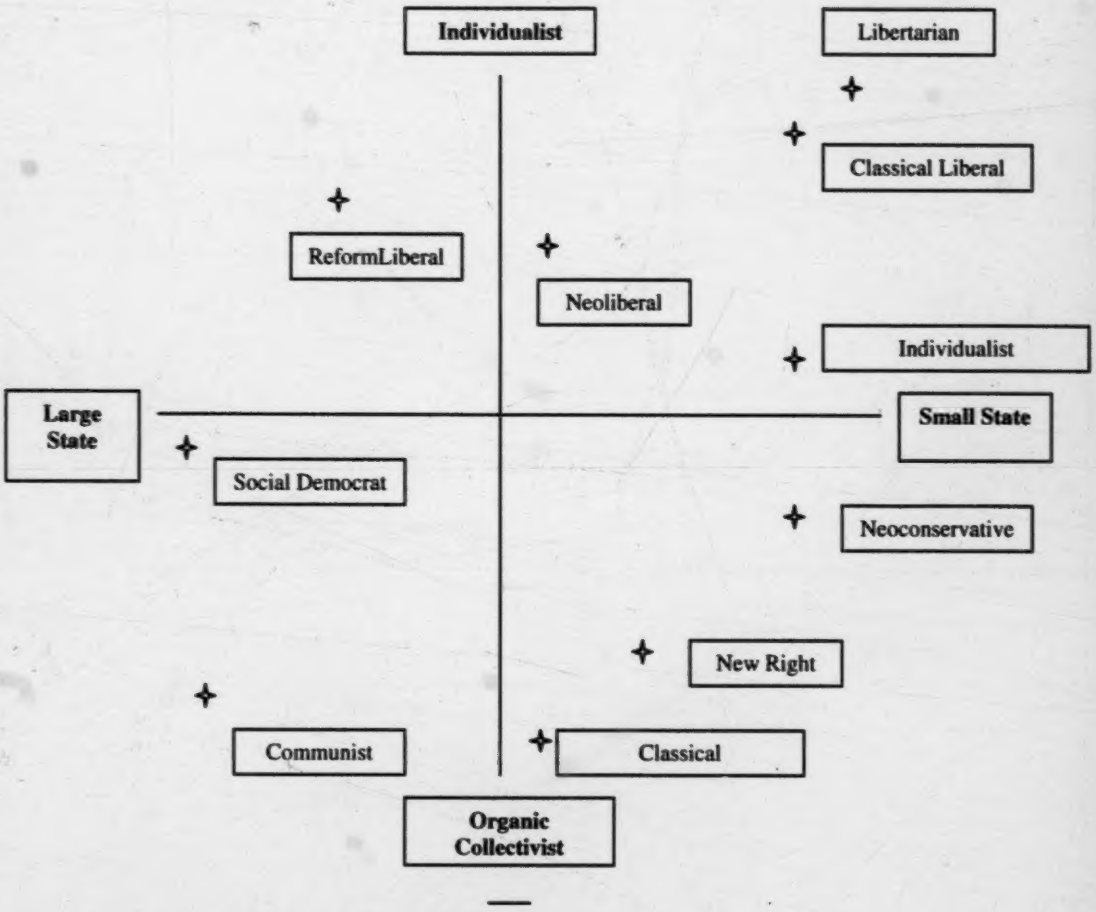
- Ascribing meanings to the actor's world around them
- Examining values and norms
- Examining the definition of the problem
- Identifying perceptions of other actors in the network
- Identifying the actors views on the nature and degree of dependency on others
- Assessing the advantages and disadvantages of collaborative strategies (Davidson, 1999, p. 47)

Davidson's approach can be used to identify the questions for the politicians, policy makers, researchers, and citizens and how they come to define and understand ideology. It will also allow us to explore the respective views of the informants about one another and their experience of working with one another in policy making. Davidson's characterizations are helpful in problematizing the orientation of the ideologies and values of the actors in the Alberta and Saskatchewan health reform initiatives.

Mapping ideology

A promising approach for mapping ideology is that of Gibbins and Youngman (Gibbins & Youngman, 1996), who plot the three primary ideological orientations (socialism, conservatism, and liberalism) in Canada along two axes: the horizontal axis that looks at whether the ideology supports a small (noninterventionist) role for the state or a large interventionist role, and the vertical axis that looks at the relative commitment toward individuality (liberty) against the organic collectivist ideology. This framework could work effectively in conjunction with the model developed by Davidson (1999). The Gibbins and Youngman model, adapted and reproduced in Figure 1, can be applied when examining the distinctions among ideological positions surrounding an issue. The first advantage of plotting a position on the graph is that it makes a statement explicit and transparent about the actor's view. By encouraging an open discussion of the ideologies inherent in the perspectives of actors, a more nuanced understanding of the social and political dynamics around an issue is likely to be arrived at. This will permit the politician and policy maker to knowledgably balance between the desirable amount of state intervention and encroachment onto individual liberties or toward more individual liberty and less state intervention in the pursuit of ever-improving population health.

Figure 1: Liberalism, conservativism, and socialism on the ideological landscape



Individualist
Libertarian
Classical Liberal
ReformLiberal
Neoliberal
Individualist
Large State
Small State
Social Democrat
Neoconservative
New Right
Communist
Classical
Organic Collectivist

Note: From Gibbins & Youngman (1996, pp. 47, 65, 96)

Making ideology explicit

Although there are many more complexities in explicating political ideologies, I am only suggesting this kind of simplistic explication as a starting or entry point. Placing one's ideological perspective or orientation on this graph encourages an open and explicit conversation as to the ideology with which one is approaching the issue. People are rarely concerned about expressing their views in respect to scientific evidence, but they may often be silent about their ideology. This model will encourage actors to defend their ideological perspective on an issue within the ideological frame. The weakness in the policy-making processes often is the fact that the influence of ideology is hidden from view and not made explicit along with other variables. In this instance, it is not debated in the same open fashion as scientific evidence, which is debated in an open and transparent forum. If ideology is negotiated or transacted behind closed doors and not engaged in an open conversation, it can often overpower HQE. Ideologies are also very complex in that, on key issues, any one individual may hold a complex variety of ideological positions. I am assuming here that people or institutions share a family complex of similar orientations. Furthermore, I also assume that value preferences are not fixed but can be open to engaged reason and change through dialogue. The objective of bringing ideology into the open and having it in the conversation along with other variables, like HQE, values, and opinions, is to encourage it to be able to stand up to argument and scrutiny on its own merits. If it fails to do so, politicians must choose between making an explicit and transparent decision based on ideology or based on some other variables. It may be that at times ideology will win out over HQE (these were referred to as "sensible" or "pragmatic" decisions by authors cited earlier) but it should be for reasons that will contribute to an overall improvement in the health status of a population. For instance, Canadians may subsidize the transport of northerners to tertiary urban centres for complex health care procedures because they cannot get access to the service in their community; we would not subsidize urban citizens in the same way because they already have reasonably easy access.

The weakness and limitation of ideological mapping

There is a danger in assuming that placing one's position in a categorical ideology on one issue means that the individual's view is always from that perspective. It is quite possible for individuals to have different ideological positions on different issues. Defining a problem requires that all actors make their interest or ideology in the issue transparent to everyone else. Another weakness and limitation of the model is that not all actors may choose to openly express their ideology or they may express the ideology by attempting to couch it in some other terms. There is no easy remedy to this other than an extremely competent policy maker who is capable of disentangling the rhetoric. A final limitation may be that dominant ideologies may attempt to "game" the ideology mapping process in order to keep a marginalized group silenced or powerless in the discourse. There is no easy recourse to this other than the scrutiny and interrogative efforts of a competent policy maker or politician.

P.A. Hall (1993) identifies that "policy makers customarily work within a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing" (Hall, 1993, p. 279). The agency of being able to define what the "problems" are is a powerful tool that is often taken for granted. In spite of the limitations of ideological mapping, P.A. Hall's observation, which is supported by the line of thinking from Osborne (1998) and Scheurich (1994), should encourage us to ensure that the development of a best practice in policy making somehow takes into account the open, explicit, and transparent expression of the actor's ideology in the policy-making process.

Values and evidence in policy making: Oil and water?

If we can get a handle on the ideology surrounding health care policy issues, how do we get a handle on the values? Having set the stage for how important it is for values and ideology to be included in the health care policy discourse, the question arises as to how values should be integrated into the evidence used in health policy making. Crichton (1981), in her text on health policy making, identified the vexatious nature of bringing values in to inform policy:

> The clash between the value judgement and economic issues manifests itself in several ways....it seems highly likely that we will continue to muddle along in our policies, swayed first by economic considerations and then by our values, unless these issues are made explicit and subjected to public scrutiny...although of course it may be that the protagonists in the debates which do take place are fully aware of this dilemma, and prefer it to remain hidden and unresolved rather than risk a possible change in public attitudes which could be unfavourable to their own approach. (Crichton, 1981, p. 311)

Twenty-four years after Crichton wrote these words the struggle continues to identify explicit ways that values can be brought to the policy-making table.

The classic contemporary text on EBDM is a book written by Muir Gray (2001) entitled *Evidence-Based Healthcare: How to Make Health Policy and Management Decisions.* First published in 1997, it is now in its second edition. In the preface to the second edition, Muir Gray (2001) writes:

> I have written this book for those who make decisions about groups of patients or populations. My overall purpose is two fold: 1. to improve the competence of health service decision-makers; 2. to strengthen the motivation of any service decision-maker to use scientific methods when making a decision. (Muir Gray, 2001, p. vii)

Muir Gray (2001) provides two reasons why a book such as this is necessary:

> … the findings from research were not being put into practice quickly and systematically because the process of decision-making was based on a random cocktail of drivers – values, resources, and evidence; decision-makers were not aware which drivers were shaping their decisions, nor which of them was most important. (Muir Gray, 2001, p. vii)

The approach Muir Gray (2001) was promoting has come to be identified as evidence-based decision making (EBDM). Muir Gray (2001) contends that decisions about patients or populations are made with a combination of three factors – evidence, values, and resources. Although Muir Gray (2001) raises the relevance of values in decision making, he does not provide a way for taking them into account and their integration into decisions. Muir Gray (2001) states:

> … although it is sometimes possible to make a sharp distinction between evidence and values, it is important for the evidence-based decision-maker to bear in mind that values are all pervasive. The assumption made throughout this book that evidence and values can be distinguished like oil and water is a necessary convenience. The reality is that our values influence the way we ask questions, collect information, interpret data, and express results. (Muir Gray, 2001, p. 372)

The objective of this project is to offer a way forward so that the "random cocktail of drivers" making health care policy today becomes a seriously concocted libation that is fair and supportive of the greater common good of improved population health of the community in the future.

Values of Canadians and health care

Suzanne Peters (1995) designed a project that explored the values that Canadians hold in relation to the three elements of the country's social safety net – health, education, and social supports. Peters gathered 15 years of public opinion data using 18 databases from about 50 polls. Peters conducted a discussion group in eight cities so that Canadians could talk to one another about their values. The study was published as a report and serves as a guide to policy makers on Canadians' values. The study demonstrates that Canadians hold values around the following themes: self-reliance, compassion leading to collective responsibility, investment in children as the future generation, democracy, freedom, equality, and fiscal responsibility (Peters, 1995, p. 5). Peters' work does two things to inform this study: it demonstrates that validated analytical techniques can be used to identify citizens' values and it identified what those values may be. The techniques of well-constructed and validated polling, opinion surveys, and deliberative juries can serve as effective means to pull the values into the health care policy-making discourse.

What do we understand of the role that values play in health care policy making? One of the first attempts to deal explicitly with values in the Canadian health care system was by the National Forum on Health values working group (1997). The working group states:

> We understand values to refer to relatively stable cultural propositions about what is deemed to be good or bad by a society. The distinction between values and such closely related concepts such as attitudes, opinions and beliefs are not, however, always clear. The most basic distinction is that whereas values are features of society and not specific to any object or situation, attitudes are understood at the level of the individual and organized or oriented toward a particular object or situation. A belief is any simple proposition, conscious or unconscious; inferred from what a person says or does; whereas an opinion is a verbal expression of some belief, attitude or value. (National Forum on Health., 1997, p. 4)

It is as a result of this treatment of the terms attitudes, beliefs, and values that I have chosen to conflate and use the term values as an expression of the cumulative community proposition or propositions of what is good or bad. I have also chosen to equally value the contribution of science and social science to create HQE as part of the politics surrounding health care reform and policy making.

Values made an important entry onto the Canadian political stage when the Commission on the Future of Health Care in Canada (2002) titled its report to the Canadian people "*Building on Values: The Future of Health Care in Canada.*" The report opens with "A Message to Canadians," in which Mr. Romanow states, "I promised Canadians that any recommendations that I might eventually propose to strengthen this cherished program would be evidence-based and values-driven. I have kept my word" (Commission on the future of health care in Canada, 2002, p. xv). Unlike the multitude of task force and commission reports from the past, the Romanow Report, as it has come to be known, did commit considerable resources from its budget to understanding and expressing the values of Canadians about health care. Romanow states, "In their discussions with me, Canadians have been clear that they still strongly support the core values on which our health system is premised – equity, fairness and solidarity. These values are tied to their understanding of citizenship" (Commission on the future of health care in Canada, 2002, p. xvi). Although the Romanow Report gave credence to the legitimacy of values in the public discourse about the future of Canadian health care, it also provided several Alberta politicians with the ammunition to accuse the report of being "ideologically" biased toward inflexible aspects of the Canada Health Act rather than encouraging innovation (private delivery of health care), which was Alberta's position. This dynamic underscores the fact that values like ideology are contested and need to be deconstructed in order to understand their relevance in the policy-making setting.

Mapping and interrogating values

Giacomini and colleagues (2001) advanced the work of the National Health Forum by further study of the question of the role of values in Canadian health care policy making. Giacomini et al. conducted a qualitative content analysis of 36 Canadian health reform documents published between 1990 and 1999, examining how the authors deal with the topic of values. The authors also conducted a review and synthesis of the literature of values theories in a variety of disciplines. Values, they found, are ubiquitous in the policy-making environment – policy makers think with them and on occasion about them. Values are contradictory, very important, and very ambiguous. The study also identified that the commonly accepted fact-value distinction is also false – "facts and values enmesh through both processes of inquiry and processes of communication. Values in scientific, professional, and policy processes produce empirical knowledge" (Giacomini, Hurley, Gold, Smith, & Abelson, 2001, p. 9). If values like evidence and ideology permeate the policy-making situation, ought they not be dealt with explicitly, openly, and transparently during policy making? They should, and a policy analyst wishing to perform a best practice will need some critical tools to help extract and understand the values embedded in facts.

Values appear in their positive incarnation – negative values are downplayed by their absence. "In health policy, for example, a familiar battle is not between those for 'equity of access' and those for 'inequity of access'; it is between those who promote equity foremost and those who promote efficiency or prosperity or some other alternative value" (Giacomini et al., 2001, p. 7). Conventional approaches to values have us focus on one or several values, often ignoring others; this is called reductionism or selective biasing. Another approach is to reject all value analysis as hopeless or to accept all values as equally credible; these are labelled as nihilistic or unhelpfully relativistic. If we bring values into the policy debate through any of these means, the outcome is less than helpful. We may cherry pick the values we want to support our intended direction and proceed with those or we say that all values are equal and, therefore, allow other forces such as evidence or ideology to trump the conversation. This is not helpful and Giacomini et al. may provide a way out of this conundrum.

Giacomini et al.'s (2001) findings and observations are that values are not just preferences or deep-rooted beliefs. Individual and collective values often are comprised of incommensurate and incomparable constituents. Since values can be this complex, we cannot assume simple techniques to determine what they are and bring them to the policy table. The social science fields of ethnography and social ethics may be excellent tools for policy makers to use in divining the values of a community. Measuring a value tells us little of what to do with them. We need social science tools to help us interpret how values can be used to inform the policy discourse. Values can be understood descriptively, that is, what they are and where they are found. Values can be understood instrumentally: how we act on them. Values are used in policy arguments about means, ends, embodiments, and representations. In the past, this usage has been done implicitly without regard for whose values were being upheld and whose were being spurned.

Identification, description, and analysis of values should look to multiple sources of information and the relative contribution of each source. The social sciences have developed methods by which values can be portrayed in imagery and other techniques, and these are underutilized around the policy-making table. The source of values should not simply be accepted at face value; they ought to be interpreted and interrogated critically, but transparently, for all to judge the fairness with which the policy process is conducted.

The language about values is complex; critically interpreting them and reading the white space between the lines is as important as the words themselves. The authors remind us to read between the lines of research evidence as well; values influence all researchers – no evidence is value free (Giacomini et al., 2001, pp. 1 - 12). Giacomini et al. provide us with a table, about which there is substantial debate as to the validity of values displayed. The table is reproduced in Table 6 and provides a framework for policy makers to think about values. The table illustrates who holds values and where they are manifested as words, ideas, or actions. These can be a guide for best practice for policy makers to use in identifying and interrogating the values surrounding an issue.

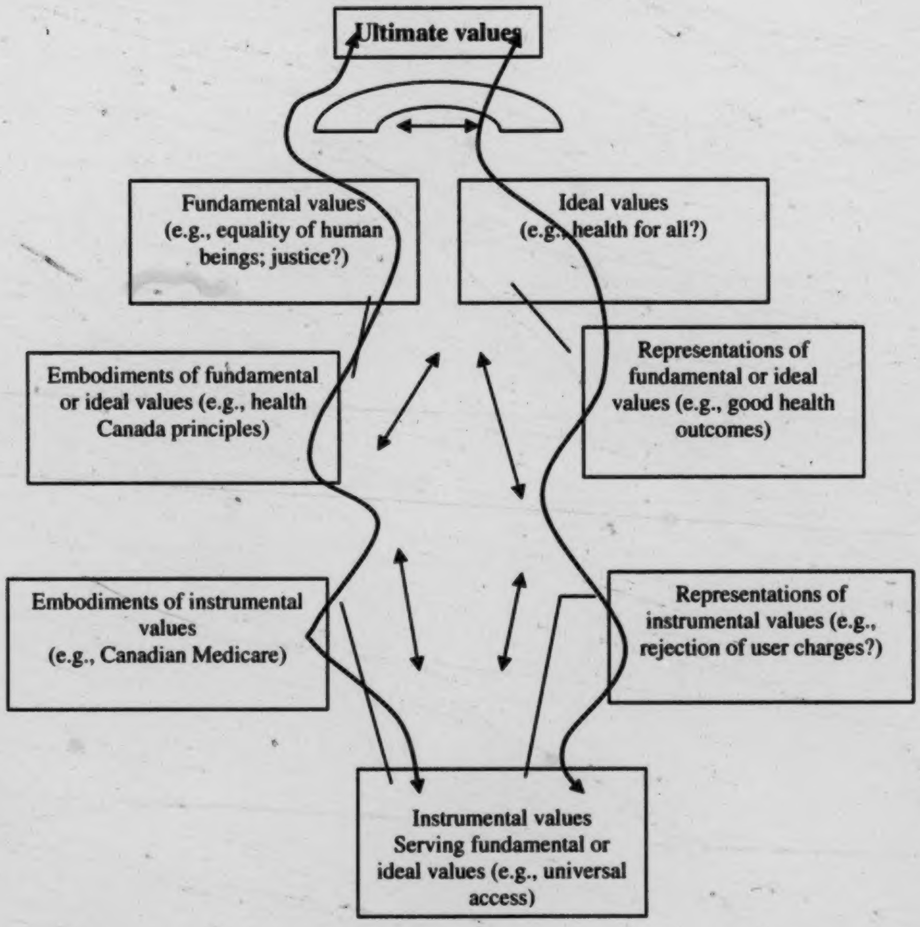
Table 6: Finding Values: An Overview of Basic Assumptions and Methods Surrounding Values

EXPRESSIONS OF VALUES	INFORMANTS			
	INDIVIDUALS A	COMMUNITIES B	HUMANITY C	HUMANS D
Ideas I	**What individuals think, feel, believe** ➢ Psychometric tools ➢ Phenomenology ➢ Preference studies 1A	**Belief systems, doctrines, ideologies** ➢ Surveys, polls ➢ Discourse analysis 1B	**Universally available ideas** ➢ Reasoning ➢ Revelation 1C	**The brain, the body, human nature** ➢ neurological decision models 1D
Words II	**What individuals say; personal meanings** ➢ n/a (only as tools for accessing 1A IIA	**What collectives say; shared meanings** ➢ discourse analysis IIB	**What "all" collectives say: universal meanings** ➢ discourse analysis IIC	? IID
Actions III	**What individuals do** ➢ n/a (only as tools for accessing 1A IIIA	**What collectives do** ➢ ethnography and related methods IIIB	**What humanity does** ? IIIC	**Human species behaviour** ➢ sociobiology IIID

Note. Boldface refers to specific locations of values; plain text offers examples of methodologies for accessing values in this location. From (Giacomini et al., 2001, p. 12).

In addition to clarifying the constitution of values, policy makers using this table will be able to differentiate between the values that are associated with means versus those that are associated with ends: the values that influence how we are going to do something versus the goals we wish to achieve. Confusion between the two in policy making is common, as was witnessed with the controversy that arose around Bill 11 in Alberta. Stakeholders that debate instrumental values (how to get somewhere: private delivery of health care) may very well be committed to the same ends (the destination: public funding of private delivery to facilitate access). The confusion arises from conflating the values of ends and means. This goes some distance in explaining the reaction of Alberta politicians to the Romanow Report cited earlier. To help further operationalize the means/ends distinction for the best practice of policy analysts, Giacomini et al. (2001) developed a second model reproduced in Figure 2.

Figure 2: A proposed model of values reasoning in policy analysis. Boxes represent types of values; arrows represent flow of policy reasoning.


Ultimate values
Fundamental values (e.g., equality of human beings; justice?)
Ideal values (e.g., health for all?)
Embodiments of fundamental or ideal values (e.g., health Canada principles)
Representations of fundamental or ideal values (e.g., good health outcomes)
Embodiments of instrumental values (e.g., Canadian Medicare)
Representations of instrumental values (e.g., rejection of user charges?)
Instrumental values Serving fundamental or ideal values (e.g., universal access)

Note: From Giacomini et al., (2001 p. 17).

The intent of the figure is to map and make explicit the values surrounding a health care policy issue that will help render it transparent and will facilitate an opportunity for values to enter into the discussion with HQE, ideology, and opinions. Rendering this dynamic discourse transparent to politicians, policy makers, researchers, and citizens may improve the chances that the public interest is better served. It also provides a foundational setting on which to begin a best practice in policy making, which can be refined as experience is gained.

Limitations and challenges of value mapping

The inclusion of values in the equation to identify strategies and alternatives for policy action in health care is at a very early stage of development and faces significant obstacles in the future. The clarion call of the Romanow Report should give us cause to feel that the tide may be turning; however, significant limitations face the inclusion of values mapping in policy making. A major limitation is that there is very little knowledge and experience with methods that have been institutionalized on how to tap into the public's values. Some work has begun in the fields of deliberative polling and the use of citizen juries, but this is very much in its infancy in Canada. A second limitation is that once the values are derived, described, and measured, the question of what to do with them still faces the policy maker. It may be necessary for the policy makers and research community to discuss the opportunity of conducting pilot projects to test the feasibility of how to integrate values in an "ends" discussion of policy implementation and evaluation. A third limitation is that contemporary society continues to have a preoccupation with an uninhibited drive for biomedical progress and technological innovation that often leaves the values discourse behind. It is not necessary to arrest society's interest in biomedical and technological progress, but it may be helpful to support more research addressing the ethical dimensions of the biomedical and technological achievements and their application. A fourth limitation and challenge that will arise is that when issues are raised about goals that are focused on improvements of population health, these will collide with the present resource and priority setting system, which is oriented toward institutional support of services to the individual and the curative model of health care. If introducing the values discussion brings up issues of reallocation of resources from the current institutional system to a health promotion and disease prevention approach, "values" may be tagged by the proponents of the existing system as an "enemy" of effective health care delivery. It will take shrewd politicians and policy makers to be able to finesse how a proper commitment to values discourse can be made without upsetting the status quo and setting the discourse even further back. A fifth and final challenge is the current growing role of the market in the state that makes it difficult to play against universal goals of population health, which requires a strong state to promulgate effective health promotion and disease prevention strategies. Payback from health promotion and disease prevention may be a generation into the future and those beneficiaries cannot vote for the government of the present.

Why privilege science to inform policy?

If scientific representations are just another ideology and scientific descriptions and explanations just another proxy for values, then politics and power clarify three senses of ideology: (a) political parties, (b) public values, and (c) "scientific" value. We need, however, a pragmatic approach to identify best evidence and best policy in a liberal right-oriented, pluralistic, democratic sovereign society. Can we make good health care policy by relying on values only? How about ideology? Opinions? Maybe; nobody knows for certain, but chances are that if values, ideology, and opinions were all well informed, they would be effective. Why is it necessary to rely on evidence or truth in order to make good policy? Tesh (1989) states, "Science is both a collection of ideological beliefs and an agency for liberation, it substitutes democracy for political and religious authority. Demanding evidence for statements of fact and providing criteria to test the evidence, it gives us a way to distinguish between what is true and what powerful people might wish to convince us is true" (Tesh, 1989, p. 167). Tesh's observation reminds us that science itself, blindly adhered to, can become an ideological distraction. Using science with our eyes open to bring together empirical observations that capture the evidence, values, ideology, and opinions will more likely improve our chances of producing good health care policy. Our goal in this project is to identify the mechanisms and criteria that will allow us to make statements on how scientific knowledge that includes the social sciences can be used to effectively inform the policy process in a sea of ideology, values, and opinions and ultimately to attempt to address questions about the welfare of its citizens.

In part response to this challenge, Saunders and Wanke (1996) developed a framework that would attempt to address the closing of the gap between researchers and policy makers. The framework focused on what type of information was required to make informed decisions rather than looking at what methodologies were appropriate. Too often in science, researchers have the power of tools and techniques that are applied inappropriately to a question that can best be answered from a social sciences or a postpositivist pragmatic perspective. Designing a double-blind, randomized control trial (RCT) is hardly an appropriate method by which to explore the social challenges of women recovering from a mastectomy – an ethnographic study is likely more appropriate. When scientific rationalism competes with community values, the social sciences can help guide and elaborate on appropriate methods. Saunders and Wanke advise:

> - In spite of a desire to think that research can easily translate into better policy decisions, in reality those decisions are fed into an environment where ethical, legal, political and other considerations must be taken into account.
> - Health services research where only a couple of variables may be manipulated only provides a piece of the puzzle – translating it to the real world is rarely straightforward.
> - Interdependence between researchers and policy makers may be encouraged but many barriers exist between them.
> - The health system being in a state of reform is witnessing changes in the roles and responsibilities in respect to health services research activities and their relationship to the providers. (Saunders & Wanke, 1996, p. 34)

These observations support the contention of this project that the qualitative methods of inquiry that provide a deeper understanding of social phenomena using the inductive method of reasoning may provide a valuable complement to traditional scientific evidence in informing health care policy discussions.

Canadian initiatives to close the HQE-to-policy gap

There is currently a great deal of activity in research funding agencies that are examining ways to close the gap between creating research and the policy-making effort. The CHSRF has taken on a major role as a leader in championing, funding, and exploring ways to effectively close the gap. The Alberta Heritage Foundation for Medical Research (AHFMR), Canadian Institutes of Health Research (CIHR) and Canadian Coordinating Office for Health Technology Assessment (CCOHTA) are exploring ways and means to achieve this. In addition to supporting research grants and awards into the knowledge transfer field, the CHSRF has undertaken a major national initiative to introduce a new actor in the health care system – the knowledge broker. The AHFMR has been developing a program, Swift Efficient Access to Research in Community Health (SEARCH), to improve the capacity of health authorities to create and apply HSR to inform local practice and decision making. The CCOHTA introduced a series of awards in January 2004 in an effort to stimulate the uptake of health technology assessments (HTAs) in the Canadian health care system. What is a concern is that adequate resources be made available to the humanities and social sciences so that they can be full contributing partners around the health care policy-making table in the creation of appropriate evidence.

Summary remarks and recapping the argument

Reviewing the conflicting evidence and way forward on the policy-making role and direction of the state in achieving universal coverage of health care is emblematic of the complexity and contingency of the phenomena and a clear indictment that traditional scientific evidence alone is insufficient for advancing the debate. The path taken by this project is different in that it *explores the literature examining the workings and characteristics of the relationships of the epistemic communities, particularly research and policy making, and recommends that drawing from validated concepts and experience from outside the traditional scientific paradigm is necessary.* The clinical sciences have been effective in informing improvement in clinical practice and in some cases administrative functions, but when it comes to the legislative and policy levels, clinical sciences and the use of controlled experiments are not appropriate for answering questions for which ethnographic analysis, ethical analysis, political science. or sociology may be more appropriate.

Part of the challenge in bridging the gap between and among the epistemic communities is how little they understand one another. Reviewing Archer's (2000) argument of embodied, practical, and discursive knowledge provides us with insight as to why epistemic communities based on different knowledge bases will have challenges in their relationships and communication. Each is the product of their socialization and assesses the social problem and research from their norm. Recent research has demonstrated that more sophisticated contexts of decision making rely on more nuanced technical models and are data based rather than being paradigm and practice wisdom based. If the respective epistemic communities are at different levels of sophistication in understanding and thinking about how to create and apply evidence, inconsistency in doing things well is likely to arise. One of the temptations in parochial policy making is to use HQE when it justifies ones position – cherry picking the evidence to support ones political position, for example. New models encouraging linkages and interaction between the epistemic communities, as well as building receptivity of the policy community, have emerged as some of the ways forward but none have identified the fundamental principle that to facilitate a meaningful interaction requires that the conversation around the decision- and policy-making table be open, explicit, transparent, and inclusive of the discourse of ideology, values, opinions, and scientific evidence. In the past, traditional scientific knowledge has been privileged in this setting. It does not mean "anything goes" in respect to what information is brought forward, but rather that validated concepts and experience from all domains should be included. Two models or maps of how to bring ideology and values into the conversation were described and provide the tools necessary to systematically and consistently approach the values and ideology conversation at the policy table. Policy by its nature is redistributive and ideology can be an effective way to protect interests during a policy debate; it therefore needs to be exposed and scrutinized as rigorously as scientific evidence that is brought to the policy table. Using the social sciences and qualitative research methods to enhance the quality of conversation around scientific facts, values, ideology, and opinions will go some distance in bringing the epistemic communities closer together in this endeavour.

The argument developed in the chapter is that the four epistemic communities hold three forms of knowledge and they place a different emphasis on those forms of knowledge. The "cross over talk" between and among the different forms of knowledge contributes to the inability of the four communities to work effectively to bring HQE to inform health care policies.

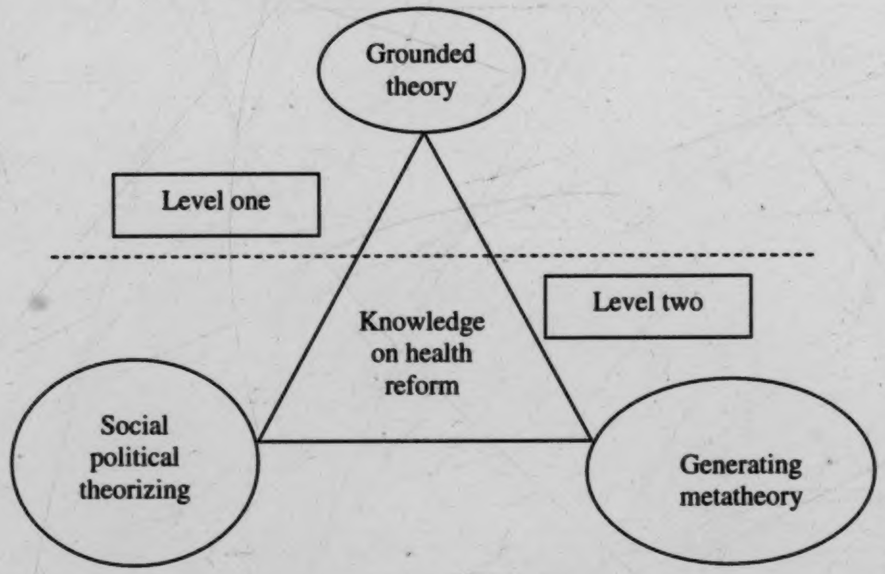
The significance of the argument in this thesis is that scientific evidence by itself is not enough to facilitate good policy making. Other factors, such as values, ideology, and opinions, must be taken into account as well. Current ideas, institutions, and interests surrounding policy making are not conducive to providing values, ideology, and opinions an opportunity for open, transparent, and explicit expression at the policy-making table. This silencing of the values, ideology, and opinions means that when HQE is presented, it may be dismissed with a spurious response. This thesis will demonstrate how a more nuanced understanding of what makes up knowledge (information about values, ideology, and opinions) can help to bring these other factors to the policy-making table and make a positive contribution. The implications of this are that marginalized voices who may not be heard around the policy-making table may be heard and that a fairer distribution of resources surrounding the priority setting of health care funding and delivery may result.

This project will inform the higher level question of how the policy-making process in health care can be modified to more effectively use sound knowledge (adding values, ideology, and opinions to scientific evidence) to inform sound policy decisions, where scientifically sound evidence is itself treated as another ideological representation and weapon in the struggle for public support and political control. In the next section, I will describe the three approaches adopted as the research design for this project. A model or theory will be developed that serves the best health interests of the wider community regardless of what ideology, values, scientific evidence or opinions are current during that time. The theory or model developed will help illuminate one possible way forward.

SECTION TWO: RESEARCH DESIGN

The three chapters comprising section 2 of the thesis describe the research design and undertake a disciplined approach to studying and analyzing health care reform in Alberta and Saskatchewan based on Pal's (2001) definition for policy analysis as "the disciplined application of intellect to public problems" (Pal, 2001, p. 13). The thesis is developed along two levels. Level 1 is at a representational, descriptive level (positivist approach) and the second, level 2, is a deeper metareflexive, critical analysis (postpositivist approach). Figure 3 illustrates the research design.

Figure 3: Research design elements surrounding knowledge of health reform.



Chapter 3 describes why GT was identified as the most appropriate approach for the study of the political dynamics surrounding health reform policy making. The research question is described in the context of a public policy problem and three subproblems emanating from it. The chapter provides a description of the methods adopted for developing the semistructured questionnaire and identifying and selecting the informants. The chapter concludes with the limitations of the study and describes how the researcher's voice and metareflexivity will be treated.

Chapter 4 broadly examines the epistemic issues surrounding the problematization of knowledge, particularly as it relates to the policy-making environment. The thesis delves into a deeper analysis of the fundamental issues of the relationship between knowledge and health care reform policy making and explores the question of what is considered to be knowledge, as well as the relationship between facts and values. These questions are important to interrogate because they may provide some clue as how to advance the pragmatic establishment of good research and good policy making. The chapter concludes with a discussion of the relationship between truth and values along one dimension and research and praxis along another. The conclusion of the chapter calls for best practice in both research (in its broadest sense) and policy making, with both communities engaged through linkages to accommodate a mediation of discourse at the policy table between scientific evidence, values, and ideology.

Chapter 5 examines the role of the state and knowledge, with a particular emphasis on the implications that arise concerning the relationship between the individual in society and the state. The tension between individual liberty and state intervention is explored with a view to identifying the challenges and issues associated with the impact of state delivered and funded health care. A postpositivist moment is indicated through the techniques of policy archaeology as a way of counterbalancing the empiricist and positivist forms of knowledge that have come to dominate the discourse at the policy table. The chapter also describes practical considerations for speaking truth to power, identifies ways of achieving best practice in policy making, and identifies deliberative democracy as a mechanism to bring together traditional scientific evidence, values, and ideology at the policy-making table.

The research for this project was designed to move back and forth between level 1 and level 2 of representational description and critical metareflexive analysis, respectively, and to provide a critical orientation toward the current problems in the health reform policy-making process. This research design sets the stage for section 3 of the thesis, which provides a historical context for health reform in Canada, with a specific focus on Alberta and Saskatchewan.

Chapter Three

GT: An approach to a comparative case of health care reform

Introduction

This chapter describes the first point of the research design triangle – a descriptive level of analysis based on a qualitative research method, GT. GT is one appropriate approach to study the social and political dynamics surrounding the discourse of ideas and the influence of evidence, ideology, values, and opinions on health care policy making in Alberta and Saskatchewan during the period 1987 to 2003 because it allows for micro-level analysis and lays the basis for inductive theory generation. Different forms of coding are at the core of GT and this offers an empirical basis to categorize or conceptualize data and findings. Theoretical coding also provides a connection to the analysis of causality, consequences, and conditions that can be connected to motives for action, as well as deeper reflexivity on the part of the researcher regarding prescriptions. Thus, GT is an important element of this research because it can be used to link my findings to more general social, political, ethical, and epistemological theorizing. I address the nature of this theorizing in more detail in the next two chapters. For purposes central to this chapter, GT is a good method of inquiry because it safeguards scientific rigour in the research process. This chapter describes one purposeful method for sampling informants, as well as the way I structured the interview processes and consequently induced the resultant themes. The chapter concludes with the limitations of the study and the treatment of the researcher's voice.

Research question

The objective of health reform is to improve, through health policy intervention, the way the health care system delivers its services to citizens so that in the future they benefit through access to necessary services and improved health status. It is the observation of this researcher that on many occasions health care policy-making activities, such as health care reform, do not take advantage of the best evidence available in the international literature. The reasons for this gap between the health care policy-making settings and those in the business of creating new knowledge through research will be reviewed and described in chapter 4. The focus of this project, however, is concerned with examining the perspectives, understandings, and relationships among four major actors in the policy community – politicians, policy makers, researchers, and citizen elites – and how they interact in relation to the use of HQE to inform policy questions. Particularly, I am concerned with understanding how forms of HQE fare in respect to other ideas such as values, ideology, and opinions, which are circulating around a policy issue.

This focus and understanding set the stage for undertaking a series of interviews with the politician, policy maker, researcher, and citizen communities with experience in health reform policy making in Alberta and Saskatchewan from 1987 to 2003. I intended to show how the politics of evidence-based health reform abated or hindered the use of HQE to advance health reform in the two provinces. The objective of the study was to arrive at a model or theory, which would help identify and develop strategies that would improve the health-policy-making process.

The research question for the study was, "*What was the interplay among evidence, values, ideology, and opinions during health reform in Alberta and Saskatchewan between 1987 and 2003, and how can this knowledge help inform politicians, policy makers, researchers, and citizens on how to improve the health care policy making process in the future?*"

Research design

The focus of this study was to interrogate the politics of evidence-based health reform in Alberta and Saskatchewan. A research design would need to take into account the role of individuals, groups of individuals, and institutions, as well as the dynamic relationships between and among them. In the fields of human endeavour such as policy analysis or politics, the social sciences, where the subjects and objects of study are individuals, institutions, and relationships, approach from the qualitative tradition is the most appropriate; therefore, this was the research design chosen for the research question – a qualitative GT case study.

I adopt two complementary definitions of qualitative research to support the approach I am undertaking. Denzin and Lincoln's (2000) definition of qualitative research is that

> It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their own natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring them. (Denzin & Lincoln, 2000, pp. iv - v)

Denzin and Lincoln's definition is mindful of the reflexive nature of qualitative research. Creswell's (1998) definition, however, is more to the point, stating "qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (Creswell, 1998, p. 15). I did not observe policy making in its "natural" setting; however, I did study the results of the policy processes and chose to speak to people involved in the process of policy making. The two definitions serve my purposes because they identify the broad spectrum of objects and relationships of interest in my study, the tools at my disposal, and the reflexive nature of the inquiry.

The study draws from GT to provide the method of inquiry. The health sciences disciplines (medicine and epidemiology, for example) on which health service delivery practices are founded are strongly oriented toward the scientific paradigm of deductive and quantitative methods. The recognition of the need for qualitative research, such as this research, to complement the quantitative research in the health research enterprise arises from the increasing complexity and rapidity of change within health care systems. Rundall (1999) comments that "qualitative research methods permit rich descriptions of the kinds of complex, dynamic phenomena that are commonplace in health care today, both at a specific point in time and as they develop over time" (Rundall, 1999, p. 1091). Shortell (1999) attributes the growing role of qualitative research methods to "the need for a more in-depth understanding of naturalistic settings, the importance of understanding context, and the complexity of implementing social change" (Shortell, 1999, p. 1083). Yin (1999) echoes the sentiments noted earlier: "Case study methods are being rediscovered in health services research. Much of the contemporary need for case studies is driven by developments in managed care systems that link their multiple components in new ways, producing 'mega-systems' of great complexity. Further, the systems' rules are in a high-flux state, continually and rapidly changing. Finally, important corporate affiliations and motivations are extremely difficult to track, much less understand" (Yin, 1999, p. 1209). The encouragement of Rundall, Shortell, and Yin for researchers to undertake richly textured analysis of contemporary problems and issues in public policy like health reform through the comparative case study is very encouraging for this research enterprise. It is for these reasons that I have undertaken a qualitative approach to the inquiry.

Research method

I selected the comparative case study approach to describe and explain how evidence is used to inform policy making during health reform in Alberta and Saskatchewan. A case study is defined as "the study of a single instance of a phenomenon either for its own sake (e.g. a particular person or strike), or as an exemplar or paradigm case of a general phenomenon, perhaps as a test of a general proposition" (Jary et al., 2000, p. 58).

Because I am examining two cases, I am extending the case study approach to a comparative level. The comparative method provides an opportunity for me to make comparisons between cases. Ragin (1989) underscores the value of comparison, saying it "provides a basis for making statements about empirical regularities and for evaluating and interpreting cases' relative substantive and theoretical criteria" (Ragin, 1989, p. 1). The strength of the comparative case method is that it provides an opportunity to compare and contrast multiple perspectives on the phenomena being examined.

The comparative case method provides for a thick description of the phenomena. Hamel (1993) warns of two weaknesses of the case method. The first is its lack of representativeness, especially the lack of representativeness as a point of observation for the social phenomenon or issue constituting the object of the study. This lack of representativeness limits the generalizability of our findings about policy making in health reform beyond Alberta and Saskatchewan. The second critique is its lack of rigour in the collection, construction, and analysis of the empirical materials that give rise to the case study. Hamel links this lack of rigour to the problem of bias (Hamel, 1993, p. 23). In this study, potential bias is minimized as to what constitutes the object of study, health reform, by taking into account several points of view of what constitutes health reform.

According to Yin (1999), in spite of these weaknesses, he feels "all of these conditions favour the use of case studies, over other empirical methods, to gain insight into these mega-systems and to assess them" (Yin, 1999, p. 1209). Yin provides the researcher with guidance on how to balance the strengths and weaknesses of the case approach to health systems research in an article that provides a description of eight desired characteristics of case studies.

1. Yin suggests using a design-oriented definition of case studies that permits a focus on a single phenomenon within its real life context, identifying the data collection method after the case study is designed, and remaining flexible, as the boundary between phenomenon and context may not be clear and the latter may change, adding a number of variables and complexity of the analysis. In this study, *heath reform and policy making surrounding it* were selected as the phenomena for the case study and the method of data collection; interviews were identified as an effective way of collecting the perspectives of the actors on the phenomena.
2. Yin warns that generalization from single or multiple cases can be problematic unless the focus is on the design as the driving definition of case studies. Consider a case study, as a unit, to be equivalent to an experiment; multiple-case studies may then be considered equivalent to multiple experiments. In Yin's

words, case studies are not "theory driven" but are "driven to theory" (Yin, 1999, p. 1212). This approach was applied in this study starting with the research design, which led to the data collection, and in turn the analysis of the data led to the construction of a theory and model.

3. Yin suggests identifying the unit of assignment early to help avoid confusion. Health reform in Alberta and Saskatchewan between the years 1987 and 2003 was identified as the study was refined and is the focus of the study.
4. Yin recommends operationalizing the case into a framework and identifying the priorities for exploration. Figure 4 is a tabular representation of the framework developed for this study.
5. Yin warns that researchers must safeguard against selection bias while at the same time maximizing the flexibility of the operational framework to facilitate discovery while the research is underway. To guard against selection bias, I ensured that the same questions were asked consistently and systematically with all of the informants.
6. Yin recommends using an emerging approach (replication logic) to define and test rival explanations as a part of the design strategy. In analyzing, reanalyzing, and synthesizing the responses of the informants into thematic entities, these were in turn synthesized into higher order themes, which began to speak for the data in an emergent model and theory.
7. Yin suggests collecting evidence from multiple sources (triangulation) to strengthen the case study evidence. In this study, I chose to interview four epistemic communities to provide differing perspectives on the same phenomena, health reform, and I relied on the primary and secondary documentation of the health reform phenomena in both provinces.
8. Finally, Yin recommends clearly distinguishing between the researcher's presentation of the case study evidence from the interpretation of the evidence. In this study, this is done in two ways. First, all direct quotes from informants are typed in *italics*; second, section 3 describes the case study evidence with some limited interpretation and section 4 describes the model and theory building.

Jreisat (1999), who addresses administrative reform in the context of comparative public administration research, theory, and practice, provides additional support for the approach of this project. Jreisat identifies two critical problems that comparative public administration and reform could turn their attention toward to achieve progress. The first is to specify the cultural determinants that have an impact on reform and the second is to identify influences emanating from or associated with the form of government (Jreisat, 1999, p. 861). For the study to be relevant, researchers need to identify the relationships between culture settings and the politics on administrative or policy reform. Comparative research will need to establish the political conditions that enhance or impede administrative reform. "Only by refocusing comparative research would it be possible to establish how the political authority system makes the difference in terms of managing public organizations. Political authority and political values not only determine the boundaries of administrative change but also shape bureaucratic attitudes toward citizens" (Jreisat, 1999, p. 867). Jreisat proposes two strategies for researchers: to move away from grand models and focus on the organization unit or middle-range theory and to conduct case studies that are relevant and based on observation and experience. "The search for administrative knowledge of reform cannot escape the need for information derived from observations of participants in the process" (Jreisat, 1999, p. 870). This study is sensitive and aware of the cultural context of the two provinces and their differences, as well as attempting to develop a "middle-range theory" that will be relevant to the policy-making community.

Figure 4 is a logic model illustrating the two cases that define the spatial boundary of the project, as well as the epistemic communities from whom data will be collected in response to the questions along the left column, the dimensions of the study. The four epistemic communities are represented by politicians, policy makers, researchers, and citizen elites. A detailed description of the questions and how they were derived is provided later in the chapter, as well as a rationale of why these epistemic communities were selected.

Figure 4: Comparative logic of study design. HQE = high-quality evidence; LQE = low-quality evidence.

DIMENSIONS OF STUDY	ALBERTA/SASKATCHEWAN			
	POLITICIAN	POLICY MAKER	RESEARCHER	CITIZEN ELITE
What is HQE and how is it used?				
What motivates the use of HQE?				
What are barriers to use of HQE?				
What are the sources of HQE and LQE?				
How should HQE be produced?				
How do you differentiate among values, ideology, opinions, and HQE?				
How are conflict among values, ideology, opinions, and HQE resolved?				
What are some improvements for the future?				

The boundaries adopted for my cases are defined spatially by the provincial boundaries and temporally between 1987 and 2003. The strength of selecting these entities is that they provide two "natural" political jurisdictions that share some similar social values but exhibit different political values. Saskatchewan is a society with stronger communitarian politics, while Alberta has more individualistic attributes. The time frame was selected because it marked the beginning of most recent efforts of the health reform processes in both provinces. In Alberta, this was marked by the provincial government undertaking the review of the health system (Premier's Commission on Future Health Care for Albertans., 1989) and in Saskatchewan, a similar review was underway (Government of Saskatchewan, 1990). The endpoint was 2003, the end of the period during which the research was undertaken and for which data were available.

Method of inquiry and adherence to rigour

Data collection

I adopted the approach of GT to structure the course of my inquiry. My unit of analysis is health reform in Alberta and Saskatchewan and the influences on health care policy making, particularly on how evidence, values, ideology, and opinion come to (or not) influence the development of that policy. Data on how health reform and policy making developed were drawn from interviews with four groups of actors: politicians, policy makers, researchers, and citizens. Supplemental data for the project consisted of primary and secondary literature, such as government documents.

Data analysis

The empirical observations of the interplay between and among evidence, values, ideology, and opinions during the policy-making process were derived from the interviews that were examined to identify the perspectives of actors and their resulting relationships. I used the systematic approach of constant comparison for developing and refining theoretical categories and their properties. This involved taking the transcripts of the interviews and extracting from them the points made by each of the 24 informants in each of the actor categories and placing them into a table by each of the questions posed. The tabulations were then further examined, grouping them by dimension and by actor into emergent primary themes by conflating and collating some and identifying others as secondary themes. A third iteration of reexamining the tabulated and collated data was conducted, further tidying up the themes and categories with a view to providing them with fully explanatory labels and descriptors. Once this was completed for each of the questions (dimensions of inquiry) and by category of actor, comparisons and contrasts among them were made, leading to the analytic part of the project. Relationships, forms of interaction, attitudes, and perspectives among the actors were noted. Incidents or events were coded into categories so that they could be grouped together and compared. Saturation was achieved when no new categories, properties, or interactions emerged from the raw data that were collected. The themes, which emerged from the categories and interactions, served as the headings for developing the theory or model for improving the health-policy-making process.

Adherence to rigour

Lincoln and Guba advance the development of standards and practice of high-quality qualitative research (Lincoln & Guba, 1985). Building on this work, Seale (1999) identifies four criteria of best practice for qualitative researchers to observe. They are the (a) truth-value of the study or how one can establish confidence in the "truth" of the inquiry, (b) applicability or how one can determine to what extent the findings of this study have relevance in other settings, (c) consistency or how replicable the study is, and (d) neutrality or to what extent the findings of the study are determined by the conditions being studied, rather than the values and biases of the researcher (Seale, 1999, p. 43). The trustworthiness of the inquiry is based on the transparency of method within the project. The project is described in sufficient detail that the reader or a future researcher could duplicate it and arrive at similar findings. My perspective in this project is to be as objective as possible in dealing with the data collected on its own merits; however, it must be noted that my perspective is that of someone who has had 25 years of experience working in the health care management, policy making, and health research settings in Alberta and British Columbia. During this time, I have been a strong proponent of identifying and finding ways to bring the best possible scientific evidence to inform health care decisions and policy. I have therefore had to be particularly sensitive to noting, understanding, and explicating the point of views of actors who may express views that are contrary to my perspective. I have done this through a judicious inclusion of quotations from the informants into the body of this study. I have also allowed the informants to review transcripts (for error, correction, revision) of the interview. I am, however, responsible for the analysis and model building that was derived from the data.

Seale (1999) informs us that "replicability is enhanced by showing readers as much detail as possible on the procedures used to generate the story being told. Reflexive methodological accounting in this spirit, based on a qualified commitment to a broadly constructed realist position, enhances credibility and can improve the quality of the qualitative research" (Seale, 1999, p. 147). Description of the approach to this study is provided throughout this chapter by identifying how the informants were selected, what the questions were, and how they were analyzed and subsequently synthesized to develop a theory or model.

The extraction, categorization, and collation of the data from the interview transcripts into tabular form using QSR N6 software facilitated the organization and constant comparison of the data to arrive at the themes that emerged. The process of synthesizing was done manually and QSR N6 provided only secondary validation, whereas the primary "instrument" of analysis remained the interpretive capacity of the researcher to explicate the key patterns and intuit the key relationships. The working documents supporting this work are retained in a secure location, preserving the anonymity of the informants, and are available for review by the thesis supervisor. Informants were notified in the invitation to participate that anonymity would be preserved by means of only the researcher and thesis supervisor having access to the data. The method and ethical validity of the study's approach were scrutinized during the candidacy exam and university ethics review (see Appendix A).

A detailed set of case study notes since the genesis of the project on March 15, 2000, has been maintained and is stored electronically and in paper record. The notes are a chronological log of all of the significant steps, events, ideas, suggestions, and discussions surrounding the project. These have been reviewed and data from them have been used to inform the design and method of the project. Table 7 reproduces the table used for this log.

Table 7: Case Study Notes

DATE	EVENT, PERSON, IDEA, SUGGESTION	IMPLICATION FOR PROJECT	ISSUE TO RESOLVE

The relevance of this study was addressed by framing a research question that was of contemporary interest to the health care policy-making communities in the Canadian health care system. This was corroborated through a review of the literature and identification of where gaps in knowledge still exist. Discussions were held with several policy makers about current issues facing the use of scientific evidence in policy making, and a pretest of the questionnaire was conducted with two knowledgeable individuals in the Alberta and Saskatchewan health care systems. Feedback from the pretest was used to modify and refine the questionnaire.

The applicability of the study's findings is heightened because of the contemporary interest in identifying ways in which the effectiveness of "medically necessary" health care interventions can be differentiated.

The use of triangulation or looking to multiple interviews to inform the questions or dimensions of inquiry helps to improve the internal validity of the project. In this case, having selected three individuals to represent each of the four categories (politician, policy maker, researcher, and citizen) in each of the two provinces provides some assurance that differing perspectives and points of view in society will be taken into account. Sources of printed or electronic data in the form of commissions, studies, reports, and periodical articles were also sought to confirm or establish facts provided through the interviews.

A clear chain of evidence was developed in the study to assure that an external observer of this research enterprise would be able to move seamlessly from the questions that had been raised, to the propositions submitted, and to the theoretical model that was developed. These led to the findings of the study and the interpretation of the data into the theory developed.

Maintaining objectivity and minimizing bias

What criteria were used to judge the degree of objectivity of my project? Seale (1999) warns of the political objection to objectivity: "The superior status claimed by science on the basis of value freedom has in practice become implicated in exploitative social relations; the separation of scientific and personal biography is in fact never possible" (Seale, 1999, p. 25). In my case, this is a serious concern, as my objectivity was under scrutiny because of my firsthand involvement in health care reform and specifically my efforts to advance the development and application of sound scientific evidence to inform the policy process. The approach I have taken by using direct quotations from my informants, which may be contrary to my point of view, and by being clear about which observations are mine versus that of the informant will assist the reader in assessing the degree of objectivity in this project.

As noted earlier, the issue of objectivity and the place of values in all types of research, particularly social research, is contested. J.R. Hall (1999) writes that "phenomenologically, the worst threat to some universal standard of reason is the human condition: knowledge amounts to one or another kind of social construction. What ever standards people invoke and negotiate for evaluating accounts produce a particular ordering regimen that shapes explanation as discourse" (Hall, 1999, p. 65).

How have I ensured that my concern for appropriate distance has not driven the design or method of my inquiry? J.R. Hall (1999) suggests disentangling two concepts:

> Whether or not the values that constitute objects of inquiry (1) have an objective basis – one that holds for people in general – or (2) are relative to a particular value – or theory and whether explanation is subjected to criteria for adjudication among accounts that are (1) independent of values other than the scientific valuation of truth, or (2) shaped by political, ethical, or scholarly values, including preference for particular theoretical or disciplinary stopping rules. (Hall 1999, p. 69)

For purposes of clarity, I reproduce J.R. Hall's (1999) characterization of these dichotomies into a cross tabulation of four ideal types of explanations of inquiry in Table 8.

Table 8: Hall's Projects of Explanation According to Value Assumption Concerning the Constructed Object of Inquiry and Criteria for Adjudication of Alternative Accounts Concerning It

		CRITERIA OF ADJUDICATION	
		Universal	**Value/theory relative**
Basis of Object of Inquiry	**Value/theory relative**	Value – neutral explanation	Interpretative explanation
	Objective	Objective explanation	Value – objective explanation

Note. (Hall, 1999, p. 70).

In this project, I am undertaking a value-objective explanation and analysis to account for how evidence is used and how other factors may influence the formation of health policy in two western provinces of Canada. The object of my inquiry is objective – the phenomenon of health care reform in Alberta and Saskatchewan between 1987 and 2003. I am not purporting or offering an explanation or theory that is universally acceptable. Rather, its explanatory power is based on its practical value: to improve the uptake of HQE in order to maximize the health benefits to the citizens. The criteria by which this model or theory should be adjudicated is in respect to how successful it is, if it were implemented, to improve the health status of citizens.

Other approaches to inquiry (the other three quadrants) are legitimate but not promoted here. For example, positivist approaches look for universal objective explanations, whereas many interpretive studies (e.g., ethnography) emphasize value-theory relative forms of understanding the object of inquiry and the criteria of adjudication.

The objects of the inquiry are objective in that most people would agree that Alberta and Saskatchewan represent legitimate political entities and the phenomenon of reform did actively transpire during the period 1987 to 2003. The basis of selecting my objects of inquiry and the criteria of adjudicating which explanations count to inform my theory are not value neutral or objective, because I have selected my entity and phenomenon of study on the basis of my field of interest and research. The project was also selected and structured with a view to identify ways in which the contested discourse on how health policy can best be structured to inform improvements in the health status of citizens in both provinces.

I am also committed to best-quality evidence. So, where my approach to the object of inquiry is primarily objective, my criteria of adjudication is value-theory related. This commitment to HQE shapes the study in ways different than for those not committed to HQE. The methods that I employed to collect, describe, and analyze the data are described in detail in this project, providing some evidence of the objectivity achieved. The content of the interviews is reproduced in *italics* in the text; however, the identity of informants is kept confidential in order to preserve their privacy. Using an objective approach rather than one driven by a value or a theory orientation discounts it as a work of critical theory or interpretative explanation. There is, however, some attempt to be critical of policy development and implementation processes that may subvert the improved health status of citizens as a result of uninformed opinions, inflexible values, noninclusive or intolerant ideology, or poor-quality scientific evidence. J.R. Hall (1999) cautions, "For the foreseeable future, multiple value-based projects of explanation are likely to continue to coexist. Within the boundaries of any given research program, agreed-upon criteria for judging the adequacy of alternative explanations under grid a value-neutral project. But because research programs are diverse, neutrality hold sonly within the program, not outside it" (Hall, 1999, p. 71). As J.R. Hall (1999) points out, this situation is not the end of the story but rather the beginning of ensuring that the inquiry becomes self-critical and reflexive. My project is founded on the belief that improvements in the health status of a population can occur if policy advice is built on high-quality scientific findings complemented by sound qualitative research that informs questions of values, ideology, and opinions surrounding a policy issue.

Purposeful sampling and the interviews

Two provinces were chosen purposively to situate the study. Two provinces with governments with different political parties in power were selected in order to show different perspectives on the problems and events I wished to study. Alberta had a Progressive Conservative government during the period (1987 – 2003), while

Saskatchewan had a New Democratic Party (NDP) government. Alberta is characterized as a province with a pro business orientation, while Saskatchewan favours a more communitarian state.

Informants identified for the study represented four different actors in the policy community: politicians, citizens, policy makers, and members of the research community. These informants were selected because they represented the individuals who were involved in the creation of health care policy during health reform in the two provinces. Others, such as health care providers and community leaders, were also involved but not at the policy-making table.

The number of individuals who could be approached to match the criteria for inclusion in the interviews was finite. The category of actor is one of public record and not open to interpretation. To qualify as a politician for the interview, the individual had to have been responsible for the health portfolio in the province between 1987 and 2003. To qualify as a policy maker, the individual had to be a Deputy Minister of Health, Assistant Deputy Minister, or Director responsible for health reform between 1987 and 2003. To qualify as a researcher, the individual would have been an executive of a provincial health research agency or have conducted a significant work to inform a health reform question in the province between 1987 and 2003. To qualify as citizen elite, the individual had to be appointed by the provincial legislature to act in an institutional role to protect the public or citizen interest between 1987 and 2003.

The small numbers of individuals who met the inclusion criteria meant that three informants in each category from each province would be appropriate. Thus, three interviews were conducted in each category of actor in each province. By the third interview, many of the observations gleaned in the first and second interview were being repeated, suggesting that saturation was being achieved.

Twenty-four informants were interviewed for this study. The categories of individuals identified for the sample are illustrated in Table 9.

Table 9: Informants by Number and Category

POLITICIAN	POLICY MAKER	RESEARCHER	CITIZEN ELITE
Member of legislative assembly with responsibility for health (6)	Deputy Minister (2)	Executive – research agency (5)	Commission representative (3)
	Assistant Deputy Minister (3)	Academic researcher (1)	Professional college executive (2)
	Director – health reform policy (1)		Public health council (1)
6	**6**	**6**	**6**

Twenty-four letters were mailed to the prospective informants, requesting their participation in the study. Included with the letter that explained the project were the interview questions, a guarantee of confidentiality, and a letter of consent to participate in the study (see Appendixes B, C, D,-E). Two to three weeks after the letters were mailed, a telephone call was made to the potential informant to determine whether they would agree to be interviewed and, if so, to arrange a date at the informant's convenience.

Informants were told that the Faculties of Education and Extension Research Ethics Board at the University of Alberta approved the project. Informants could drop out of the study at any time. All interviews would be held in private and in confidence in a location of the informant's choosing. It was explained that the interviews would be recorded and transcribed. Informants would have an opportunity to review a transcript of their interview and to make corrections, additions, or deletions. The interviews were scheduled over a 4-month period from July to October 2003. Table 10 illustrates the distribution of the interviews over time.

Table 10: Interview Schedule With Informant by Province

2003	POLITICAN		POLICY MAKER		RESEARCHER		CITIZEN ELITE	
	ALTA	SASK	ALTA	SASK	ALTA	SASK	ALTA	SASK
July				1		2		1
August	3	3	2	1	1	1	3	1
Sept.			1	1	1			1
October					1			
Total	3	3	3	3	3	3	3	3

Of the three Saskatchewan politicians identified in the first letter of invitation, two accepted and one was unavailable; an alternate was approached and accepted the invitation. In Alberta, of the first three politicians approached, two accepted and one was unavailable; an alternate was approached and accepted the invitation. Of the three policy makers approached in Saskatchewan, all accepted and of the three approached in Alberta, two accepted and one recommended an alternate, who met the criteria and accepted the invitation. Of the six research representatives in Alberta and Saskatchewan identified, all accepted. Of the six citizen elites in Alberta and Saskatchewan approached, all agreed to participate.

The engagement of informants in the time taken for interviews varied considerably. No perceptible pattern (partly because of the small numbers) in degree of engagement among the actors was discernible. The interviews were scheduled for 1 hour and ranged from 47 minutes to 104 minutes. Table 11 provides an illustration of the interview times by informant and by province.

Table 11: Interview Time (in Minutes) by Informant by Province

POLITICIAN		POLICY MAKER		RESEARCH		CITIZEN ELITE	
Alta	Sask	Alta	Sask	Alta	Sask	Alta	Sask
47	48	65	67	59	95	55	78
69	96	62	65	64	57	51	67
65	92	104	43	54	55	77	67

As shown in Table 12, the majority, 15 of the 24 interviews, were between 50 and 70 minutes in length.

Table 12: Length of Informant Interviews in Minutes

MINUTES	INFORMANTS
40 – 50	3
50 – 60	6
60 – 70	9
70 - 80	2
80 – 90	0
90 – 100	3
100 - 110	1
Total	24

The interview started with a brief introduction of the researcher and the project being undertaken. On conclusion of introductions, the consent and guarantee of confidentiality forms were explained and completed. The interviews were recorded digitally with the informants' consent. In all cases, a copy of the semistructured guide was provided to the informants at the time of invitation to participate so that they had time to think about their responses to the questions prior to the interview. The interviewer asked the questions in turn, allowing the informant to respond. In some cases where the answer was not clear or there was an opportunity for elaboration of a point, the interviewer did ask a further question. The interviewer also amplified on a point if requested by the informant. The interview process could best be described as semistructured, allowing for some discourse or exchange.

The interviews were transcribed through a bonded transcription service within 2 to 4 weeks after the interview was completed. The researcher reviewed the transcripts against the audiotape for accuracy of transcription. A covering letter with a copy of the interview was mailed to the informant with instructions to respond within 3 weeks with any corrections, changes, additions, or deletions. Informants were aware that they could drop out of the study at any time. If the informants did not respond within the 3-week period, it was assumed that they accepted the transcript as provided. This was confirmed by telephone or e-mail in all cases. Twelve of the informants responded with minor spelling or grammatical changes; the other 12 accepted them as prepared. In no case was there a concern with the quality of transcription.

Interview data and its analysis

The 26.7 hours of digital audio files of interviews were transcribed into a Word database organized by informant by province and by response to each question. The interviews amounted to 394 pages of transcript, single spaced with 10-point font. The software QSR N6 was used to extract and code the responses from each of the informants by province and by the 18 questions. Each of the questions and their responses for each informant became a "free node" in the database. In the next step, each of the free nodes was analyzed in detail and data were extracted and grouped into a database of the 18 questions, with each of the informant's responses grouped by category of actor. For example, question 6, "What stimulates the movement toward high-quality evidence being used in policy making?" listed the extracted salient comments for each category of actor. This synthesis resulted in 40 pages of data, which were in turn reanalyzed and reconstructed into tables by grouping the responses to questions into emerging themes but keeping the responses that were specific to each group of actors, as well as between the two provinces, separate. The 18 questions were combined and grouped into five primary categories:

- What is HQE and how is it used?
- What motivates the current movement toward use of HQE and what are the barriers and confounding factors?
- What are sources of HQE and poor-quality evidence and how should HQE be produced?
- How do you discriminate between and among values, opinions, ideology, and HQE and how have you seen conflicts among them resolved satisfactorily?
- What are improvements you would recommend for health care policy making?

Part of the analysis compared and contrasted the responses from Alberta and Saskatchewan respondents, noting the salient points. These data were then reanalyzed and four large tables were constructed in the first step toward constructing a theoretical model based on the data. The four tables helped identify a "suggestion category" that emerged from each of the salient points that were derived from the synthesized raw data. The suggestion categories were then reanalyzed and synthesized with the observations, conclusions, and theories arising from the scholarly literature and categorized into the elements that emerged as the four elements of the model and theory for this project. All direct quotations from the respondents are illustrated in italics throughout the thesis.

Limitations of the study

This project is a comparative case study of the politics of evidence-based health care during health reform in Alberta and Saskatchewan during 1987 to 2003. The experiences and observations derived from this study are limited to only those jurisdictions and that time period.

This thesis is about the interplay, negotiation, and influence of ideas in health care policy making – ideas in the form of ideology, opinions, values, and HQE. There are many other forms of influence in the politics of health care policy making, such as the availability of resources, power relationships, interests, interest group politics, institutional structures, and the authority of the state. This project does not diminish the importance of these, but rather takes them into account within the mediation that takes place among the ideas that are in circulation. Reframing the transactions in the policy-making environment as being an exchange of different forms of ideas (which may have interests at their core) and making them transparent, open, and explicit to the public may improve the chances that HQE is more frequently sought. In addition, by reframing an understanding of qualitative evidence about values, ideology, and opinions that are necessary to inform policy making, a greater contribution might be made to improve the health of the community.

A further limitation of this study is that it is based on the views of four epistemic communities that form a sizeable but limited portion of the health care policy-making communities. The opinions of other actors, such as administrators, health care providers, and the general public, were not sought because they were outside the scope of this study. It should be noted, however, that several of the informants interviewed fulfill or have fulfilled several of these other roles in society during their careers.

The informants interviewed for this study were relevant actors considering the period from 1987 to 2003. Therefore, another limitation of the study may be recall bias, as some of the informants may not have been active in their roles for several years. No relevant or noticeable recall "problems" or "effects" were observed during the interviews.

The project makes the assumption that the use of high-quality research evidence to inform health care policy will likely lead to improved health status of the population. Although it seems intuitively correct that valid and appropriate policy-making activity will lead to better results, this is difficult to determine because of the indeterminacy of the relationship between health care policy interventions and the improved health of individuals or populations. This dilemma will be examined later in the chapter. Finally, it must be recognized that, although a model of how to think about and advance the transaction of ideas (HQE, values, ideology, and opinions) has been derived with suggestions for a way forward, these are still representations of reality – this map or any map is not the same as the territory.

Researcher's voice

One of the limitations, as well as strength, of the study is the influence that the perspective and knowledge of the researcher may have had on the project. Having 25 years of experience working in the health care management, policy-making, and research communities of the health care systems in British Columbia and Alberta comes with certain disadvantages and advantages. The disadvantages are that the years of experience have provided a certain view of the world that may colour the objectivity of the study, even though caution was exercised to allow the informants' words to speak for themselves. Second, the researcher's enthusiasm for the use of HQE in both quantitative and qualitative forms to advance the integrity, accountability, and relevance of the policy-making process is itself an ideological position that needs to be approached critically and openly. This study does not claim any inherent epistemological superiority, but it does show the weaknesses of other claims, which may not be as inclusive or tolerant. A third concern is that of being politically aware to not "upset" or alienate current power structures in which the researcher must continue to work and live. The safeguards in response to this shortcoming are to allow the data to speak more for themselves in the spirit of openness and transparency without compromising anyone's confidence or security. Important as well for limiting subjectivity was the knowledge and experience of the supervisor and supervisory and examining committees.

The advantages of coming into the project with years of experience is that it provided an opportunity to identify and explore questions and issues that were gaps in the current understanding of the relationship between the policy-making and research communities. Much of the research has been focused on specific aspects of the relationship but none to date had taken into account the broader dimensions in the negotiation and transaction among ideas and how they influence the policy community. The emergent research in this field is beginning to address this issue, but the tensions between the quantitative and qualitative approaches that exist are still significant barriers to progress. A final advantage is that the years of experience have confirmed many of the findings in the scientific literature that the policy-making process is extremely complex, with an iterative nature that has conflicting goals and objectives, confounding a government's ability to do what may be in the public's best interest in the short term.

Chapter Four

Generating metatheory: Associated epistemic issues and problematizing knowledge

Introduction

This chapter provides the analytical structure for thinking about knowledge. It provides the metareflexive means to reflect on the way I and my informants thought about knowledge and its relationship to values and ideologies. This chapter describes the key categories I used to reflect on the findings from a GT approach to the case study. This epistemic reflexivity is illustrated by the second point of the research design triangle (Figure 3) under the designation: generating metatheory. Having reframed the policy problem and attendant research subproblems, chapter 3 identified GT as a way forward to research about values, ideology, and opinions. This chapter explicates the form and substance of my metareflexive inquiry in an effort to think more deeply in a disciplined manner about that which is articulated in debates in the sociology and philosophy of knowledge. The significance of more reflexivity on epistemological matters is twofold: (a) the naive approach to the "politics of knowledge" in health care research and reform and (b) the untapped plethora of existing research on the study of "knowledge" from philosophical, historical, and sociological sources. This chapter places the framing of the research question, the case study approach, methodological design, analysis, and findings of the research and the generation of theory within the broader context of epistemic issues surrounding inquiry and knowledge creation. Metareflexivity is disciplined in three ways: (a) conceptually, (b) methodologically, and (c) normatively.

First, "conceptual" questions are rarely addressed in the research literature because of the hegemony of positivist assumptions in my particular field of study, which seems to have been oblivious to the methodological debates over "legitimate" knowledge of the past 30 years in the natural and social sciences. This thesis takes seriously the dilemmas raised in the postpositivist debates from the point of view of pragmatism, hermeneutics, poststructuralism, and critical theory and attempts to incorporate a few elements of metareflexivity as one small contribution to reframing the debate about the use of knowledge in health care reform by problematizing knowledge. Thus, this chapter situates the research problematic within the broad spectrum of intellectual inquiry and the many contentions over the nature of knowledge.

Two conceptual issues are identified and addressed early in the chapter, the "indeterminancy" problem manifested between policy action and the outcomes at the population health level, and the "measurement" problem related to the challenges associated with measuring something called "health." These two problems raise another conceptual issue: how to address the consequences (negative and positive) of the appropriate role of the state in the health of citizens. I defer on the theoretical discussion of the appropriate role of the state to the next chapter. Suffice it to say here, the question of the state in turn raises another metareflexive conceptual issue of how to identify and operationalize "good" policy making in a society, which I focus on here. The concept of epistemic communities as developed by Haas (1992) and Miller and Fox (2001) are introduced and used as one way to advance our understanding and explanation of how communities adopt and act on different forms of knowledge.

In addition to conceptual issues, this chapter also develops a second metareflexive element regarding methodological issues through the examination of researchers who have tried to bridge and reconcile the divide between the positivistic and the postpositivistic approaches to research. I have selected the work of J.R. Hall (1999) and Danermark, Ekstrom, Jakobsen, and Karlsson (2002) because of their explicit approaches to the problematic divide between positivism and postpositivism and their identifications of potential ways forward on this issue. The work of Clemons and McBeth (2001) solidifies this approach in the policy analysis field, with their identification of the need for pragmatic policy making to bridge relativistic nihilism on the one hand and restrictive absolutism on the other. Although there are other ways to tackle the knowledge problematic, the research assumptions of J.R. Hall, Danermark et al., and Clemons and McBeth had significant influence on how I presented the final text of this thesis and organized the research design and on how I thought about my findings resulting from a GT approach to the case studies. The metareflexivity encouraged by J.R. Hall and Danermark et al. provides a foundation for the metareflexivity on the thesis as a whole –

a commitment to use theory as a potential way to reconcile the effective use of facts and values in policy making. In addition to deductive and inductive reasoning to advance the thinking on the problematics in this thesis, the concepts of retroductive and abductive reasoning are introduced as ways to help frame old problems in a new way.

In addition to conceptual and methodological issues, a third metareflexive element is introduced in this chapter through a normative debate introduced by Max Weber (1947) on the relationship between facts and values in scientific research and the impact of values on the social sciences. This chapter identifies the ways I thought about the relationship between fact and value and, therefore also, the relationships among various knowledge and values, ideologies, ethics, politics, and power. As a starting point, I relied on the concept of Weber's (1947) ideal types as a way to think through to my analytical model and my metaphorical model derived from the research findings and later used to establish my prescriptions regarding best practice in policy making in the last chapters in the thesis.

After addressing the way I approached conceptual, methodological, and normative issues, the chapter concludes with the identification of two mechanisms called "linkages" and "accommodation." I identify and return to them in the later chapters and use them to identify bridges between the research and policy communities. The process of accommodation provides a setting where the logical coherence of any scientific and social sciences practice can be brought to the policy-making table, thereby creating a bricolage of policy discourse. This approach underscores the view that knowledge is socially constructed and approaches to it should be sensitive to the cultural setting. However, while knowledge is socially constructed, it is not linguistically arbitrary nor without substance in respect to the reality it represents. Thus, the chapter concludes with the observation that not all knowledge is equally meritorious and that mechanisms and criteria for adjudication can be developed from within the various fields and domains of inquiry. In keeping with the ontological and epistemological assumptions of J.R. Hall (1999) and Danermark et al. (2002), while there may be more than one correct interpretation of reality, there are those interpretations that are necessarily incorrect and must be judged empirically illegitimate. This shifts the debate to criteria regarding *legitimacy* of representations and not necessarily regarding *reality*. These criteria of legitimacy may not be appropriate or relevant for universal adjudication but they do serve the particular discipline. A question thus remains and is addressed in this thesis: How can we adjudicate different understandings of knowledge that originate in different disciplines? In addressing this final question, my own recommendation in the last chapters is to suggest a form of "deliberative democracy." However, the point of raising this question in this chapter is to highlight that it is a question worth asking in moving the agenda forward. As I have done here, I end this chapter with encouragement to the policy community and social sciences community to theorize and publicly debate their responses to contemporary policy issues.

What this thesis is

This thesis is an attempt to take a fresh look at and explain the dynamics surrounding knowledge creation and policy making during health reform in Alberta and Saskatchewan from 1987 to 2003. Lakatos (Lakatos in Hall, 1999) suggests that a project of this kind should open up new ways to think about the world. Classic studies of policy making have focused on interest group interaction, stakeholder analysis, roles of elites, professional dominance, and exchange theory. This thesis operates at two levels: the representational, describing and analyzing how health reform is perceived and acted upon by the epistemic communities, and the critical level, in which I seek to look at new ways to interpret and explain the behaviour, particularly in reframing the dynamics among "scientific evidence," values, ideology, and opinions, which become privileged in informing health policy making.

Health reform by definition is a programmed approach by government to introduce public policy that will improve health care delivery to citizens by changing existing structures. This project uses social science as a form of social criticism to serve as a vehicle to study and identify socially emancipatory objectives and means that can replace existing undesired social structures with desired structures. The literature review provides an appreciation of why social systems like health care delivery become so entrenched and intransigent in their character. As a form of inquiry, this thesis is postpositivist. It studies and analyzes ideas that are the centre of health care policy making and politics but with the awareness that these are battles between and among ideas that are socially constructed categories of shared meanings of the epistemic communities. Approaching the challenges of identifying a way of conciliating the use of evidence, values, ideology, and opinions in policy making in a meaningful way, a theory or model is developed in order to provide a clear vision of where praxis may go in the future in an effort to establish a best practice, where it is argued "best practice" is not possible. The model and recommendations for best practice in policy making derived in this thesis are not the final word, but provide another step in forcing the resolution of a "constraining contradiction" between how politicians and policy makers say they should act and how they do act. Theory building and development of practices are an iterative process building on the lessons of the past and exploring new opportunities for refinement as they emerge.

What this thesis is not

This is not a study of policy making in the traditional sense in its various stages of agenda setting, policy development, policy implementation, or policy evaluation. It does, however, draw from this field, which is well addressed by Canadian academics such as Pal (1997, 2002), Howlett and Ramesh (Howlett & Ramesh, 2003), and Weimer and Vining (Weimer & Vining, 1999), among many others. This study is not about knowledge transfer between the research communities and the policy-making communities. The study is not focused on knowledge utilization and policy-making. It does, however, rely on the works of Lomas (1990,1997); Landry et al. (2001); Lavis et al. (2001, 2002); Lehoux, Tailliez, Denis, and Hivon (Lehoux, Tailliez, Denis, & Hivon, 2004); and Lemieux-Charles and Champagne (2004). Their work has led institutional structures in Canada such as the CHSRF to address the weaknesses in the knowledge-to-praxis continuum by introducing mechanisms and incentives to bridge new knowledge and the practice settings. This thesis is a critical study of the social and political dynamics surrounding the discourse of ideas and the influence of evidence, ideology, values, and opinions and their relative impact on health care policy making. The objective is to develop a theory and a prescriptive model that can help improve the likelihood of ensuring that the interplay of evidence, values, ideology, and opinions being adopted in policy making will lead to improvement in the health status of individuals and citizens of the community.

Indeterminacy between policy and health status

One of the challenges linking the creation of new knowledge and its application to policy making in the practical world is that it may be difficult to demonstrate a corresponding relationship between a specific form of policy intervention and improved health status of a community. This issue is analogous to the issue of representativeness of the "real world" to attempts of inquiry of that world. The discouraging of smoking in a population and demonstrating an immediate improved health status due to the "latency effect" may be one reason that governments may be reluctant to become involved in banning smoking in public spaces. Politicians and policy makers may be reluctant to take steps today that annoy the citizens by eroding individual autonomy (to make the choice of smoking in public or not) for a benefit of improved health status in the future.

An analogous situation in the realm of policy making arises in the field of inquiry. The causal link between social phenomena and explanations is not as firmly established in the social sciences as it is in the natural sciences. Social scientists can demonstrate a necessary relationship between an object of study and its causal mechanisms, but the relationship between the etiological mechanisms and their effect is contingent. The natural sciences are conducted in closed systems where experiments can be controlled with explanations and predictions made; in the social sciences, the systems of study are open and change is continuous, making prediction impossible. This character of social science will help to inform how knowledge creation can best be used by the policy-making community and will be discussed later in the research-to-praxis section.

Background to the research question

The research question for this study is to interrogate "What was the interplay among evidence, values, ideology, and opinions during health reform in Alberta and Saskatchewan during 1987 and 2003, and how can this knowledge help inform politicians, policy makers, researchers, and citizens on how to improve the health care policy making process in the future?" The question was framed in this way in an effort to understand and explain why politicians and policy makers would act expeditiously at times, ignoring good evidence that would have suggested a course of action when a "healthier" course of action was emerging as a result of new knowledge creation. A case in point is the issue of prohibiting smoking in public spaces – the hazards of smoking to health are well documented but some governments are reluctant to take action – the assumption behind this question is that if we understand better the dynamics associated with this tension in policy making, we may be able to identify and recommend a constructive course of action to improve choices being made. What is it about the ideas (evidence, values, ideology, or opinions) circulating around the policy-making table that causes some good ideas to gain traction into public policy while others languish? The data surrounding mortality due to lung cancer are indisputable and preventable – yet they appear to not motivate action in promoting a healthy public policy. If you live with and watch a loved one die of lung cancer due to chronic smoking, you are not ever likely to question the wisdom of smoking. As an individual, one can hold a belief that there is an indisputable relationship between smoking and lung cancer, but a state will only act on restricting individual autonomy on smoking when there is a general acceptance by the citizens that the benefit of restricting smoking in public outweighs the negative consequences of encroaching on individual autonomy.

A study such as this faces many epistemic issues, some of which are the age-old questions faced in the broader context of inquiry and others are more particularizing. I will address a selection of these in turn.

Measuring health status and outcomes

Associated with the indeterminacy between policy action and individual or population health status is the challenge of measuring the health status of a population and the resulting outcomes from health care interventions. One can never *truly* define or measure the health status of an individual or a community. One can only come to an approximation through surrogate measures like mortality, morbidity, and quality-of-life indicators. This issue of measurement and attribution of benefit or harm due to health care policy intervention also causes policy makers to be wary of taking action where the association may appear tenuous. It may also be one of the reasons that some politicians express cynicism about public administration efforts of health care reform and begin to explore mechanisms of the marketplace to reform health care delivery, which no longer serves the public interest in its current form. The position of this study is that these weaknesses do exist, should be recognized, and should become the focus of attention for future research and resolution. Social phenomena are dynamic and the means to study them should reflect this dynamism.

Role of the state in health care

The ideological as well as pragmatic debate as to how much the state should be involved in the affairs of its citizens is an age-old challenge, which continues to play itself out in Alberta and Saskatchewan. This study would suggest that Saskatchewan has a higher proclivity for communitarian or state intervention in the affairs of citizens when it comes to health care funding and delivery than does Alberta, which is more likely to side with individual responsibility and market mechanisms. Ironically, it is Saskatchewan that has fewer resources to direct toward public services. It may be that the relative scarcity of resources in Saskatchewan leads it to be more conscious of how to use evidence to inform more parsimonious policy solutions that are nonetheless oriented toward communitarian service. This contrast in the political values of the two provinces goes some distance in explaining the different capacities and considerations of the two states in the use of HQE and mediating that with opinions, values, and ideology to achieve the best outcomes for its citizens. The question that arises is, "What, if any, effect does this have on the policy-making machinery of government?" "What lessons does it provide us with what best practice in health care policy making should look like?" The evidence as to whether states with strong and effective research capacities that inform policy making are better off, in respect to health of the community, than states with weak research capacities remains unanswered; however, it is identified as an area for further research but not of central interest here. It is a point to be proven rather than presumed.

Defining good policy making

Just as good health is hard to define and is contested territory, so is the question of what constitutes good policy making. The lack of a universal definition for good health should not prevent us, however, from seeking it, for the alternative is something most agree they would prefer not to have – poor health. In the interviews, one former Deputy Minister of Health pointed out that there could never be such a thing as a best practice in policy making because it was a craft and needed to take into account the nuances of so many factors: HQE, values, ideology, and opinions. Charting the waters of effective policy making was not like following or writing a recipe for baking a cake – it was much too complex an affair to be condensed into rules of best practice. For a government to remain popular, it had to do things, which may not be in the best "public interest," but would endear its popularity to the citizens. One politician had a contrary view and felt that "doing the right thing" in spite of public sentiment was the only "political" course of action. This thesis takes a normative position, siding with the latter politician, and attempts to demonstrate that one of the ways toward improved performance in policy making is for it to be based on the best evidence and to conduct the policy discourse in an open, transparent, and explicit way so that all communities and interests can see and judge the merits of the process on their own account. One finding of this thesis is that if the public could be educated to "a higher watermark" of understanding of the evidence, values, ideology, and opinions that would lead to improved health, they would not as likely be alienated from the government, and policy makers would be much more enthusiastic in pursuing policy action sympathetic to the public's health. An informed population clamouring for the prohibition of smoking in public spaces (being ahead of the policy makers) would be an example – as opposed to one fractured by business interests concerned with declining revenues due to clientele not attending their establishments because smoking was not permitted. This appears to be fundamentally based on the substance of how and on what the respective epistemic communities are educated.

Establishing the epistemic communities of interest and political analysis

Classic works examining health care politics and policy making have identified and selected different policy actors and communities to interrogate the contribution and influence of each on the policy-making process. Eckstein (1960), in his sentinel work, examined the case of the British Medical Association and their influence on health care policy making in the United Kingdom (Eckstein, 1960). Eckstein's approach was an analysis of pressure group politics. Alford (1975), in his examination of health care interest group behaviour and politics in the United States, focused on the struggle between the professional monopolists and the corporate rationalizers who represented competition between different sectors of the health industry for control of sources of profits. The analysis examined the ideological and interest group barriers preventing effective health care reform in the United States (Alford, 1975). Analysis moved away from pressure group studies with the landmark work of Barbara and John Ehrenreich (1971), when they examined the American health care system and accused it of constituting a "medical-industrial complex." (Ehrenreich & Ehrenreich, 1971). In Canada, Weller (1980) found many of the approaches wanting and undertook an analysis of the development of approaches to the politics of health care in Canada and concluded:

> …there are secular and dynamic forces at work within health and society that most of the approaches have failed to take into account, no doubt because of their ideological foundations. It follows, therefore, that analysis of health policy must attempt to identify these forces, not only for the purpose of explaining how health systems have developed, but to provide some means of evaluating the policy positions and actions of the participants in the present systems. (Weller, 1980, pp. 338 - 339)

This thesis responds to Weller's (1980) challenge and takes a different approach to the analysis of influences on health care policy making: instead of competition among interests, hierarchies, networks, or markets, *this project focuses on the circulation and competition among ideas, contradictions arising among them, and their influence on health care policy making*. The ideas are of four types: HQE, values, ideology, and opinions. Other "ideas," such as beliefs and attitudes, are subsumed under values and ideology. This is not an approach that has been attempted before. It has been undertaken in response to the critiques that conventional approaches have been inadequate. The thesis will also take the approach of closely examining the perspectives of the four epistemic communities selected for this study: politicians, policy makers, researchers, and citizen elites.

The four groups, politicians, policy makers, researchers, and citizen elites, identified and selected for this project as instrumental in the transaction of ideas in the larger health reform policy-making community, are not members of one single conceptual category. To categorize them as a "system of professions" would be inaccurate, as they do not share a common practice or code (Abbott, 1988). Interest or pressure group would not be appropriate, as they cut across such a broad section of the political domain (Pross, 1986). Elites may have been appropriate, except they would not meet the criteria of a "positive commitment to maintaining the ongoing system" (Presthus, 1973. p. 13). A final category that appeared appropriate at first was Sabatier's (1986) advocacy coalitions, but they function as networks organized around a set of normative and causal beliefs advocating for policy change (Zito, 2001). Politicians and policy makers are the target of advocacy coalitions. The concept and dynamics that appeared to prove the best theoretical fit for the four groups selected was "epistemic communities."

The conceptualization of epistemic communities as used in this thesis is based on the work of Haas (1992), who states that they arise from a shared set of normative and principled beliefs serving as a value-based rationale for social action of community members. The epistemic community shares a common policy enterprise, with a set of causal beliefs derived from their studies of problems and issues, which describe linkages between possible policy actions and preferred outcomes. The epistemic community also shares an understanding of validity with internally defined criteria for weighing and validating knowledge in their field (Haas, 1992). The definition in this thesis is modified to take into account the fact that the groups chosen for this study do not "share a common policy enterprise" but may be heterogeneous.

The framework developed by Haas does not include other participants like policy makers and the wider public, a point on which he has been criticized (Zito, 2001. p. 467). *Of the* *four epistemic communities identified in this project, it is only the researchers who systematically produce new knowledge in the original sense of the term. Politicians, policy makers, and citizen elites tend to act upon the knowledge that is produced for them by members of the research community that may be employed or commissioned to undertake studies. For this reason, I differentiate between the core epistemic communities, represented by the intellectuals, researchers, and think tanks, and the extended epistemic community, which relies on anonymous members of the core epistemic community to provide it with ideas.*

Miller and Fox (2001) highlight that, for epistemic communities, "justified belief …is a matter of social practice. Members of the epistemic community share norms (albeit contested and revisable) about how good research should be conducted" (Miller et al., 2001. p. 681-682). The four epistemic communities at the focus of this study (politicians, policy makers, researchers, and citizen elites) were selected because of their immediate proximity to the policy-making process. They represent the primary locus of ideas surrounding health reform. Interest groups, such as the medical associations, business lobbies, and health provider associations, also promulgate very strong influences in the "community of ideas," but in this project they are captured within the expression of the four epistemic entities.

The heterogeneity of epistemic communities may arise from what they consider to be valuable knowledge. This is a constructivist moment in the thesis, identifying that in the epistemic community of researchers there are scientists who are positivist, post positivisit, hermeneutic and critical realist in their orientation to the philosophy of knowledge. These sub-communities of the researcher epistemic community value different types of knowledge. The conflicts among scientific evidence, values, ideology and opinions of these sub-communities lead to the politics of method. On the broader scale, each of the epistemic communities has commitments to different types of knowledge and this leads to the conflicts and the consensus between and among the epistemic communities. Recognizing that the social sciences and broader scientific communities are organized around certain knowledge that they value, I attempt to extend the horizon of legitimate knowledge produced and used by policy-makers beyond traditional scientific knowledge to include embodied practical and discursive knowledge.

Value judgements regarding the types of knowledge used to inform the debate in health reform are most often implicit. If value judgements were introduced explicitly and articulated as part of the reflexivity in the policy making process, it may lead to interactions that will lead policy makers to share openly what they define as valid and legitimate knowledge. This would lead to an increased consciousness and recognition that there are different forms and types of knowledge that should be challenged and contested in an open and deliberative context. In a study of health reforms in a non-reflexive setting, specific problems may arise and not be adequately interrogated because specific interests distorted communications. This results in a problematic. Finding a way of resolving the problematic and making the process reflexive to move it forward without denying anyone's voice, should result in an improved process of policy-making. Each epistemic community presupposes that its knowledge is the legitimate knowledge, and introduces a moment of deliberative democracy as a way of opening up the discourse to demonstrate that the debate is not only about knowledge, but the production of knowledge.

Pragmatic epistemological issues

The issues identified earlier are an example of those that are experienced in the practical world of health care policy making. Within the epistemic community of researchers, there are many debates currently raging that are fundamental in respect to the following: What is knowledge? What counts as knowledge? How is knowledge to be created? Is all knowledge created equal? These are age-old questions about which a considerable amount of thought and energy has been expended, the refinement of which continues to this very day. This thesis does not profess to answer these questions, definitively, but it does take as its starting point the work of J.R. Hall (1999), which examined the debate and identified a third path between that of absolute knowledge achieved through positivism on the one hand and unrelenting relativism at the other. J.R. Hall is not alone in professing this position. Danermark et al. (2002), in their examination and promotion of critical realism in the social sciences, state, "critical realism constitutes a 'third way' in the scientific debate between on the one hand empiricism/objectivism, and on the other hand relativism/idealism. However, it is not a conflation of, or a compromise between, these perspectives; it represents a standpoint in its own right" (Danermark, Ekstrom, Jakobsen, & Karlsson, 2002, p. 202). Critical realism is defined as a "doctrine reconciling the real, independent, objective nature of the world with a due appreciation of the mind-dependence of the sensory experiences whereby we know about it" (Blackburn, 1996, p. 88).

J.R. Hall's (1999) and Danermark et al.'s (2002) dialectic synthesis of the debate allows us to move forward with the same authority and confidence of believing that just because we are not able to definitively define health that should not prevent us as individuals and communities from moving forward to achieve good health. By analogy, because best practice in health care policy making is difficult to define and is contested is no reason to not aspire toward it.

Researcher's perspective

In the previous chapter, I addressed the issues surrounding the researcher's voice in a project such as this. Related to this is the fundamental issue of any enterprise of inquiry and the researcher's perspective in the knowledge-creation process. The issue is captured by J.R. Hall (1999) in Table 13. It illustrates the different types of meaning generated by the different perspectives. The first frame, that of the actor within his/her community, in the case of this project, is the subjective world orientation of the politician, policy maker, researcher, and citizen. The second frame of reference is that of the lifeworld of the researcher (observer in J.R. Hall's classification) – this would be my lifeworld orientation based on my experiences about which I have been explicit earlier in the chapter. The third frame is that of the objective – observer or researcher. In this thesis, this is my perspective based on the tools and skills that I have developed, collected, and used over the years to apply systematic and consistent approaches to study questions and to reduce bias from my study and work. This is generally done through mechanisms of openness, transparency, explicitness, and reflexivity with the work so that the reader has the full benefit of knowing exactly where the researcher is coming from in respect to their perspective, as well as explicating the chain of evidence from the research question, to assumptions, limitations, data collection, synthesis, analysis, explanation or interpretation, and finally model or theory generation.

Table 13: Frames of Reference and Meaning by Actor and Observer

	Frames of Reference		
	Social actor's lifeworld orientation	**Observer's lifeworld orientation**	**Observer's objective orientation**
TYPE OF MEANING	Subjective meaning	Observer's subjective interpretation	Observer's interpretation of meaning in objective context

Note. From J.R. (Hall, 1999, p. 18).

It is important to make this transparent because the framing of the problem will dictate the solutions that are found. The analogous scenario in the policy world is that how the problem is defined dictates the solutions that are considered. If a question is framed from the perspective of health care providers versus the state or the patient, the findings and solutions will differ significantly. In addition, no particular perspective is necessarily privileged: multiple frames of reference are known to coexist and should be explicitly exposited in a policy discourse. This approach allows us to respect different perspectives without identifying them as wrong or illusionary. The perspective that I take in this study is societal and democratic – the primary benefit of health care delivery by the state should be for the benefit of its citizens. Benefits, which are secondary, do accrue from the health delivery system to providers, policy analysts, and politicians in the form of wages, reputation, and political capital, but their interests should not eclipse that of the health benefit of the citizens.

In this study, I attempt to discern the informant's subjective meanings in relation to what they believe to be the role and influence of HQE, ideology, values, and opinions in the process of health care reform policy making. I am interested in comparing the differences and similarities between and among the actor's meaning in two provinces. I am also interested in reconciling the differences in what they say or mean and their actions. I do this by developing categories of ideas that emerge from the data that can help me understand and explicate this.

Object of inquiry

Another debate in academic circles is the definition of the object of the inquiry. This debate is founded on the fact that characterizations of social structure and phenomena are arbitrary social constructs based on some observer's subjective interpretation of the world. My choice of the two provinces at a specific temporal span of time and the perspective of four groups of actors can be argued to be entirely arbitrary (relative) or biased (absolute) because of my experience and interest. My experience in the policy-making and research communities ignited an interest in trying to identify ways in which those things that I *know* as being sensible for improving the health status of a community might stand a greater chance of being accepted in policy circles when confronted with values, ideology, or opinions, which may be ill informed. J.R. Hall (1999) characterizes all inquiry as having some cultural foundation, which chooses some particular way or frame of reference to describe and interpret the *real world*. No particular world view is privileged but it is shared (or not), either more or less generally, with the general community. The question that arises is whether that perspective is selected objectively or subjectively. This study was undertaken with an agenda in mind – that of understanding and explaining why HQE is often trumped by values, ideology, or opinions when it comes to health care policy making. Understanding this dynamic was only half the equation – ultimately what I wished to do was to develop a theory or model of knowledge creation and policy making that would improve the chances that HQE would improve the health status of individuals or that communities would stand a better chance of adoption. Although the goal of this study was subjective, how to improve the chances of HQE being used to inform health care policy making, the approach, and the method of the study was objective. The approach to how the data were collected, analyzed, and interpreted and how the theory was constructed are clearly described. The entire process from research problem definition, to identification and selection of epistemic communities and informants to be interviewed, to textual data selected for analysis, and to collation of the data and its conflation into a model or theoretical model are provided transparently to the reader should he/she wish to replicate the study or move it to the next stage of validation.

To better understand the issue of objectivity in a research study, J.R. Hall (1999) illustrates "how values shape ways of accounting for sociohistorical phenomena, two dimensions often conflated with one another need to be disentangled: (1) whether or not the values that constitute *objects of inquiry* (a) have an *objective* basis – one that holds for people in general – or (b) are *relative* to a particular value – or theory – based frame of reference, and (2) whether explanation is subjected to *criteria for adjudication* among accounts that are (a) *independent* of values other than the scientific valuation of truth, or (b) *shaped* by political, ethical, or scholarly values, including preference for particular theoretical or disciplinary stopping rules" (Hall, 1999, p. 69).

In this thesis, the values that constitute the objects of inquiry are relative to a particular value or theory-based frame of reference; that is, knowledge in various forms can advance the health of the citizens of Alberta and Saskatchewan, which forms the objective basis of my inquiry. The criteria for adjudicating the merit of the study is based on the criteria of conducting good qualitative research, associated with the work of Clive Seale (Seale, 1999).

To set the stage for why it is necessary and important to be transparent with the selection of the object of inquiry, J.R. Hall cites Foucault: "Ideological elements do not necessarily undermine knowledge claims of inquiry, and, by the same token, that increased rigour and clarity do not purge inquiry of ideology" (Hall, 1999, p. 70). My desire to see an improved effectiveness of HQE, values, ideology, and opinions negotiated in policy making is evidence based; however, it also has an ideological foundation. Having an ideological proclivity toward the use of HQE and encouraging its use by the public and policy makers does not preclude the possibility of conducting an objective study that can help inform an improved approach to policy making.

J.R. Hall's (1999) treatment of the criteria for adjudication, reproduced in Table 8, illustrates that

> ...interpretation is simply explanation that occurs under conditions in which multiple criteria of adjudicating among accounts remain in contention with one another. Under this condition, different theories may produce knowledge about a given phenomenon, each in relation to its own standards of evaluation. In other words, interpretation is a special case of explanation, and it faces parallel problems of adjudication. (Hall, 1999, pp. 138-139)

This project is based on an object of inquiry that is value-theory relative and the criteria for adjudication within it are value-theory relative, making it a work of interpretative explanation.

Fact-value distinction

Weber (1946) resisted the idea that values could be justified scientifically. In "Science as a Vocation," he argued that, despite the power of science, it cannot answer questions of ultimate meaning. "Scientific pleading is meaningless in principle because the various value spheres of the world stand in irreconcilable conflict with each other" (Weber, 1946, p. 147). I use this as a starting point not to privilege the role and contribution of evidence, values, ideology, or opinions over one another. Just as there is a continuum of evidence that ranges from poor quality to high quality, so there is a continuum of values that are poor to good, and the same with ideology and opinions, which can be fully informed on the one hand and ignorant on the other. The challenge is, of course, in finding ways that critically differentiate among the good and the poor in a meaningful way that does not inappropriately trample on individual autonomy and/or dignity, but rather enhances the emancipation of the individual or community. In contemporary pluralistic times when political dogmas and the authority of many values, ideology, and opinions compete equally, it is highly unpopular to enter into a discourse of differentiating among them or rating their merit. However, if values, ideology, and opinions are to enjoy the same consideration at the policy table as HQE, the conversation about their intrinsic relative merits will need to be discussed and debated explicitly, openly, and transparently. Politicians, policy makers, researchers, and/or citizens cloaking their ideological values or opinions behind a veil of pretence is what this project is attempting to bring out into a form of reflexive dialogue and encouragement.

Science can help us differentiate between good and poor scientific evidence, but it is of little help in differentiating among good versus poor values, ideology, or opinion. The social sciences can, however, come to our aid. Studies from the fields of sociology, political science, psychology, linguistics, policy analysis, anthropology, and economics (to name a few) can be very informative in helping differentiate among values, ideology, or opinion that is in the interest of individual or community health (Willinsky, 2000). One major value commitment of this study is that *it makes a strong plea for the increased use of qualitative research from the human and social sciences to help fill this gap and inform policy making*. Policy debates, to be truly emancipatory, will need to bring values, opinions, and ideology to the table, but alternative value commitments are certainly welcome to the debate if not defended here (Cohen, 1999b). Although this type of commitment to scientific rationalism is somewhat constraining, it is also, I argue, enabling, not just for this study, but also for social reform.

A word of caution needs to be taken. The caution comes in response to a question that is put to the social sciences: Can they in the current evidence-based movement live up to the promise of delivering useful products? The answer appears to depend on what they may be asked to provide. In the opinion of Shulock (1999), the social sciences may be less about problem solving and more about clarifying issues and informing the public discourse (Shulock, 1999, p. 241). This is important advice to take into account as we think about the development of best practice in policy making. Another potential issue identified is that criteria for evaluating the social sciences may not be as well developed as they are in the quantitative sciences. It is the case that criteria are contested, but this is not an impossible feat. The quantitative sciences continue to refine their techniques in systematic review and meta-analysis and there is no reason why the social sciences cannot be extended the same courtesy. An important contribution of the social sciences that is noted by Young, Ashby, Boaz, and Grayson (2002) is its potential role in helping to inform the public. "Research can serve the public good just as effectively when it seeks to enlighten and inform in the interests of generating a wider public debate. Not evidence – based policy, but a broader evidence-informed society is the appropriate aim" (Young, Ashby, Boaz, & Grayson, 2002, p. 223) . The traditional approach appears to be unnecessarily restrictive of the contribution that the social sciences can make, for example, in forming policy issues surrounding values.

Deductive versus inductive reasoning in inquiry

This project did not start out with a hypothesis and in turn the testing of assumptions in order to arrive at a deductively generated model. Instead, it began with the framing of a research question relevant and timely to the research and policy communities, and collected data about the perspectives of the selected communities with a view to prescribing a way forward. There is a debate in the inquiry of knowledge as to whether inductively generated findings have the same status as deductively arrived at findings. Rather than enter this debate, we use as a starting point the findings of Rundall (1999), who advises that social phenomena such as policy making are too complex to be understood solely through deductive means and that other forms of knowledge generation carried out systematically and consistently provide the only way forward. In his words, "qualitative research methods permit rich descriptions of the kinds of complex, dynamic phenomena that are commonplace in health care today, both at a specific point in time and as they develop over time" (Rundall, 1999, p. 1091). Shortell (1999) affirms this position and attributes the growing role of qualitative research methods to "the need for a more in-depth understanding of naturalistic settings, the importance of understanding context, and the complexity of implementing social change" (Shortell, 1999, p. 1083). It is for these reasons that I have undertaken an inductive qualitative approach to the inquiry instead of a deductive hypothesis-testing approach. As with my pragmatic and democratic commitments to scientific rationalism, alternative approaches to scientific rationalism are welcome to the debate but not defended here. In this age of epistemological pluralism in a democratic society, to privilege science or one form of scientific rationalism would most certainly promote dogmatism at the expense of democratic pluralism (Kachur, 2002).

J.R. Hall (1999) identifies a second reason for the value of inductive reasoning and theory building, which arises from Miller and Fox (2001), who "argues that undue emphasis on deductive theory in sociohistorical inquiry unnecessarily undermines the potential of explanation, for deductive theories are likely to be most robust when causal factors are relatively easy to identify, observe and measure. Yet these conditions, Miller suggests, are the very ones where the gain from explanation is limited: theoretical explanation thereby evidences a "bias toward the superficial" that can be corrected only by efforts to achieve greater "causal depth" (Hall, 1999, p. 149). We will see from the data that politicians and policy makers have become wary of the superficiality of many explanations and have all but lost confidence in the research community providing them with advice to advance the public's agenda.

There is a third reason that J.R. Hall (1999) brings to our attention why inquiry arising from "impure logic" of the inductive qualitative approaches can be helpful in advancing the practice of inquiry. Contemporary conflicts over knowledge and what constitutes legitimate knowledge have an unfortunate effect: They reinforce ideological divisions at the very time when there is an opportunity to better understand the complex web of uneven connections that structure the entire range of inquiry's practices (Hall, 1999, p. 229). Limiting HQE that informs policy making to the scientific fields of epidemiology, biostatistics, and clinical trials limits the wealth of knowledge that can help inform the broader questions of the health of the community. J.R. Hall points out that

> Even projects that share the same research agenda, discipline, interdisciplinary enterprise, or emancipatory endeavour may diverge from one another in their methodological practices and the character of knowledge produced …Thus, no practice can claim the epistemological superiority of an unalloyed logic based on isolation from the contaminated reasoning that plagues other practices. In any multiple dispensations, sociohistorical inquiry is an exercise in impure reason. (Hall, 1999, p. 230)

Health care policy making may suffer from the same isolation by relying only on the positivist approaches and miss the opportunity for making further advances in improving the health of the community through a more nuanced understanding of health needs, which may arise from qualitative research being brought to the policy-making table. Broadening the scope of what knowledge can be brought to the table is not necessarily synonymous with accepting poor-quality evidence, values, ideology, or opinions. Because we can't do surgery in a germ-free environment doesn't mean we choose to do it in a sewer either. As in surgery, research does not have to choose between absolute certainty and radical relativism. There are in-between spaces providing room for some plurality and certainty. Wholesale relativism is not the spectre that necessarily results. Similarly, the quality of the work must merit excellence and robustness in its methodological approaches. It may be that good-quality research from different approaches reaches different conclusions about the same social phenomena. It does not mean that one is wrong and the other correct, only that they are derived from different perspectives. J.R. Hall (1999) contends that "a great opportunity will have been lost if the old divide persists between a hollow epistemology of pure Reason and shallow denials of the potential for reasoning" (Hall, 1999, p. 257).

Danermark et al. (2002) identify two additional forms of inference or thought operation for inquiry: abduction and retroduction. Abduction is "to interpret and recontextualize individual phenomena within a conceptual framework or set of ideas. To be able to understand something in a new way by observing and interpreting this something in a new conceptual framework" (Danermark et al., 2002, p. 80). Retroduction, on the other hand, is "from a description and analysis of concrete phenomena to reconstruct the basic conditions for these phenomena to be what they are. By way of thought operations and counterfactual thinking to argue towards transfactual conditions" (Danermark et al., 2002, p. 80). Unlike deduction and induction, abduction and retroduction may or may not use formal logic. The central issue in abduction is to derive what "meaning is given to something interpreted within a particular conceptual framework" (Danermark et al., 2002, p. 80) and to identify "what qualities must exist for something to be possible" (Danermark et al., 2002, p. 80). In addition to induction, this study undertakes to use the retroductive and abductive logics to identify best practice that may advance the use of new knowledge to advance the health care policy-making effort in a community.

In support of my approach, I refer to a statement Habermas made in a speech he delivered when he accepted the Theodor Adorno award in Frankfurt in 1980. Habermas drew on the work of Weber (1946) and his differentiation of science, morality, and art, which were derived from Kant's three critiques: truth, ethics, and aesthetics. Habermas states that "the three spheres developed in autonomous directions, each increasingly staffed by a cadre of experts whose professional knowledge separated these spheres from the lifeworld of praxis" (Hall, 1999, p. 257). This, Habermas contends, can only be cured by an unconstrained interaction of the cognitive with the moral-practical and the aesthetic-expressive elements; he called for a blurring of boundaries among the three spheres. This becomes the point of departure for Lyotard (as cited in J.R. Hall, p.257), who points out that the quest for consensus cannot be a principle that enforces legitimacy of knowledge and no pragmatic metalanguage that bridges the practices of inquiry can be codified. If Habermas would mix Kant's three spheres, Lyotard affirms their inevitable differends (Lyotard in Hall, 1999, p. 257). The dialectic that arises between that of universal method and the differend becomes the feedstock that contributes to a more enlightened discussion at the policy table rather than privileging one form of knowledge over another. An open discussion and debate of what policy alternatives are really possible is more likely to be an emancipatory discourse, with attendant subsequent action, than if the conversation is constrained.

Reflexivity

In this thesis, I undertake to be as explicit as possible in respect to what are the lifeworld views of the subjects (my informants), my own lifeworld views, and my objective perspectives and approaches to the study. I provide the reader with an introduction to my perspective (subjective lifeworld view) on the issues and the approaches and methods I utilize to achieve my objectivity. In order to provide the reader with an appreciation of the informants' perspectives, I include their quotations in response to my questions. My synthesis of the findings derived from the interviews is contained in chapter 11, where I originate a model or theory of how the challenges and issues of improving the use of a broader understanding of research can be used to advance policy making.

Method and theory

In his book, *Cultures of Inquiry*, J.R. Hall (1999) explores sociohistorical inquiry as an analogue to inquiry itself, an arena contested by alternative practices of inquiry. My study is an examination of the different practices of inquiry, many contested (outside and within their domain), and how they can more effectively inform health care policy making. The positivist sciences like epidemiology, biostatistics, double-blind RCTs, and operations research are well established in informing policy, but the qualitative approaches of sociology, political science, ethics, policy analysis, and anthropology, for example, are not yet making a full contribution. This study attempts to explain why, as there is a great deal of knowledge that these other domains may be able to contribute that would improve the health of citizens if they were factored into the policy-making process.

J.R. Hall (1999) identified four forms of discourse: values discourse, narrative discourse, social theory, and discourse of explanation or interpretation. In his words, "any practice of inquiry presupposes some stance about how to theorize, and similarly, about the ways that values, narrative, and explanation or interpretation come into play" (Hall, 1999, p. 27). In short, "practices of inquiry are shaped by the formative discourses on which they draw." J.R. Hall goes on to elaborate that "any given practice of inquiry is a dialectical supplementation of other practices, positioned simultaneously as a negation of them and as an affirmation of an alternative method. But the *logical* coherence of any practice is belied by the way in which it draws multiple forms of discourse into a *bricolage*. Its coherence is cultural, not purely logical" (Hall, 1999, p. 29). J.R. Hall feels that this understanding will "help address questions about whether differences in knowledge – even concerning "the same" phenomenon – are prefigured by the formative discourses and research practices through which inquiries are pursued" (Hall, 1999, p. 29). By analogy, I am using the research that explicates and brings to the table values, ideology, and opinions for an open forum of discussion so that they can contribute to the *policy bricolage.*

The link in this project between the method and theory is explicitly described. The conflation of the verbatim data from the interviews is drawn into tables, from which the primary structure of the model originates. The theory or model that emerges is my response to creating a policy bricolage that is necessary to improve the health reform policy-making process.

Truth and values

J.R. Hall (1999) states that "knowledge produced through inquiry may be relevant only to those individuals who accept the value significance of the inquiry, even though proponents of particular values may proclaim relevance of knowledge for a much wider audience, by asserting inquiry to be objective in its methods, and thus supposedly objectively relevant for everyone" (Hall, 1999, p. 41). This observation was confirmed during the course of this study with the example of researchers who claimed that politicians or policy makers would at times "cherry pick" evidence to support their particular values or ideological perspective. In other cases, a researcher would argue for the superiority of his or her view by virtue of the study having been conducted "objectively." J.R. Hall reminds us of the slippery slope "between truth and other values, science becomes the servant of politics" (p. 41). But Weber (as cited in J.R. Hall) emphasized "scientific truth is precisely what is *valid* for all who *seek* the truth" (Weber in Hall, 1999, p. 41). Even if truth is sustained epistemologically, its relevance is purely cultural, not based on any objective, universal value. This is why in this study I am interested in the perspectives of the different actors in the epistemic communities on the influence of values, ideology, opinions, and HQE on policy making. J.R. Hall identified three responses to Weber's value problem: (a) unrelenting value relativism, (b) positivism and other proclaimed formulations of objectivity, and (c) critical theory as value affirmation. This thesis is not entirely critical theory based, but it is critical in its postpositivist approach on how to improve health care policy making.

J.R. Hall (1999) is supported in his position by Danermark et al. (2002), who accept the idea that all knowledge is relative in respect to being socially constructed, but not all knowledge is of equal merit. The authors differentiate between epistemic relativism and judgmental relativism; the former accepts that knowledge is contingent – historically determined – while the latter accepts that one form of knowledge can be judged as being preferable to another. Danermark et al. conclude, "We can find criteria by which the convincing force of a theory can be measured, at many levels: historical, emancipatory, critical and instrumental" (Danermark et al., 2002, p. 80). The value of this thesis will be judged in terms of its explanatory power and utility in bridging the dynamic relations between knowledge creation and policy making.

I have chosen a blend of the second and third options as a way forward in this thesis. The higher order principles to which I hold the truth value are the moral principles of democracy and human emancipation to achieve their full potential.

Research and praxis

The challenge for this project was to identify a way forward in spite of the debates within the research community on the one hand and the dynamic competition among the HQE and LQE, flexible and inflexible values, emancipatory versus paternalistic ideology, and informed and uninformed opinions to advise public policy on the other. It should also be understood that there is no definitive ultimate solution as to how to bring evidence effectively to the policy-making table. There are only incremental improvements as time goes on. This view is confirmed by Danermark et al. (2002), who state:

> When the requisite knowledge is to be applied to people and societies, we must be aware of the fact that detailed tangible prescriptions of how to do things once and for all will prove untenable. If social scientists, despite this, start formulating prescriptions they use the authority of science in a basically unfounded way. The nature of social phenomena entails that it is a realistic understanding of the driving powers behind all the different, ever-changing social occurrences – the understanding of causes – rather than more mechanical knowledge that determines whether different actions will have the expected effects. This also means that practitioners, themselves must have access to the tools consisting of theoretical and analytical concepts, that is, what are commonly regarded as the specific tools of scientists. What social scientists should provide practitioners with is not prescriptions but social scientific theories. This is the only foundation for planning that we can provide. (Danermark et al., 2002, p. 189)

What Danermark et al. hint at, Clemons and McBeth (2001) identify explicitly. The policy analysis and teaching of policy studies "have largely run along two tracks that rarely intersect" (Clemons & McBeth, 2001, p. 176). One track is the positivist track, which has dominated the policy field, and the other is postpositivist and emergent. The focus of the former is on "calculability, generalizability, stability, rationality, and proceduralism" (Clemons et al., 2001, p. 176). The latter "suggests that the role of the analyst is not to find the truth, but rather to be suspicious and distrustful of all policy claims and ultimately to provide access and explanation of data to all parties to empower the public to understand analyses, and to promote political issues into serious public discussions" (Clemons et al., 2001, p. 178). Clemons and McBeth also identify a second form of postpositivism, which is concerned with the participation of citizens in problem definition, identification of alternatives, and selection of policy. The distinction made by Clemons and McBeth underlines the need for us to think about achieving a balance between the positivist and postpositivist approaches to health care policy making. This project has endeavoured to contribute to the bridging of knowledge between the positivist and postpositivist application of social knowledge to health care policy making.

Best practice

Building on the approach of Weber (1947) in establishing *ideal types* against which to compare and analyze the lifeworld, I have undertaken to establish the parallel concept of "best practice" in government, policy making, research, and citizenship as something for individual emancipation and society to aspire toward. The criteria by which we would adjudicate what is good versus bad government, policy making, research, and citizenship would be taken from the perspective of what is best for the emancipation of individuals in a community. In chapter 11, I identify the starting points for best practice in policy making and research. I have not addressed the issues of what is best practice in citizenship or politics, as that is outside of the scope of this study.

The best practice in differentiating among the merit of values has less to do with what they are than with how they are held and acted upon. If we are unprepared to consider the bringing in of values, ideology, and opinions to the policy-making table so that they can be explicitly and openly debated along with the scientific evidence, that, too, says something about the way we hold our values. Perhaps they need to be modified. Since there can be no scientific method by which to affirm good versus bad values, an important dimension of adjudicating on values is to look at how they are held. Holding on to values in an inflexible way (dogmatism), regardless of the consequences for the individual or community interest in the form of health status, may be one means by which to adjudicate.

Communities in discourse: Linkages and accommodation

In order to adjudicate among the conflicting values, ideology, opinions, and evidence in the sphere of health care policy making, a necessary ingredient is democratic discourse that facilitates full public participation. As one politician pointed out, when it comes to doing unpopular public policy that may be in the best interest of the broader population, what is necessary is a general increase in the public's knowledge of the issues and the risks and benefits associated with differing policy options. A government often has to be in a very strong position electorally to undertake an unpopular policy practice. This involves the education of the public into participating effectively and being well informed in the public policy issues. Each of the four epistemic communities felt that they would benefit from having a better understanding of the issues confronting each of the other constituencies, which is the reason for the title of this thesis, *Educating Publics and Policy Makers: Epistemic Communities and the Politics of Evidence-Based Health Reform in Alberta and Saskatchewan*. A better appreciation of epistemic communities' issues and problems could be achieved through improved linkages among them.

This project suggests that the discourse around public health policy making move beyond the confrontation, negotiation, and accommodation of differing interests and instead move toward the accommodation and mitigation of ideas, namely, evidence, values, ideology, and opinions, with the model developed in chapter 11. The form that accommodation would take place is that it would have to be transparent, open, and explicit to the public. No knowledge, values, opinions, or ideology can be privileged to another without a full and open discourse and debate in the public sphere. The effectiveness with which individuals, a community, or society achieve an improved health status because of policy action would be some indication of the traction the policy had in the lifeworld.

Some politicians in Alberta tended to have a cynical view of the researcher community. Saskatchewan politicians, on the other hand, were more likely to identify the value of creating new knowledge to bring to the public policy-making table. However, as one Saskatchewan politician freely admitted, his adherence and support of the knowledge production activity in the province itself was an ideological position in an attempt to change the status quo – and inform where health reform should go in the future. The politician also noted that when his government took power, some of the bureaucrats were reluctant and resistant to the health care reform policy agenda. This observation is confirmed by the work of Sabatier (1986), who notes, "In short, elected policy makers – whether they be a local city council or a national cabinet – can seldom exercise effective control over street-level bureaucrats in the sense of keeping the latter's behaviour within tightly circumscribed limits" (Sabatier, 1986, p. 315). In the Alberta context, politicians were much more concerned with the research community advocating certain ideological positions, and, to them, there was no difference in ideas put forward by researchers than there was for the other interest groups in Alberta society vying for influence on the public policy process.

Policy makers in Saskatchewan were much more likely aligned with the research community than was the case in Alberta. Policy makers in Saskatchewan identified ways in which to build on the new knowledge being created, while policy makers in Alberta felt that they were being called upon to produce evidence that was not available but yet supportive of the ideological orientation of the government. This was most dramatically experienced when an entire cadre of senior bureaucrats was transferred from Alberta Health and Wellness after the controversy surrounding Bill 21, resulting in the assent to the Health Care Protection Act.

Chapter Five

Social and political theorizing: The role of the state and knowledge

Introduction

Chapter 3 explicated the relationship of GT to the comparative case studies and chapter 4 identified the conceptual, methodological, and normative metaissues regarding knowledge. The final element of the research design concerns the role of social and political theorizing in the research process. This last corner of the research design triangle (Figure 3) attempts to illustrate that there was no linear progression in the way the three key elements of the research design interacted. The triangle model merely attempts to point out the different ways to think about the objects of analysis: the "use" of "knowledge" in the "health reform process."

Chapter 5 begins with the normative position that in liberal democratic pluralistic society, an approximation of the truth is more likely to advance the discourse at the policy table than a rigidly universal rule for accepting or rejecting facts and values. The chapter discusses the tension between individual liberty and state authority and the assumptions that have informed contemporary debates in Canada. There is a context of historical and social development for health care to have arrived at the current debate surrounding health reforms, and there have been competing ways to explain the reforms. Central to this study are the provinces of Alberta and Saskatchewan. They represent two outliers in which the former province is committed to experimentation with market mechanisms in health care delivery and funding, while the latter is committed to a communitarian approach. The polarization of debate seems to generate more heat than light, so I shift the discussion away from interests to ideas and identify the conception of deliberative democracy as one potential way to resolve some of the continuing tensions among the ideologies that inform the key debates over health care reform.

In addition, the chapter identifies the policy archaeology of Osborne (1998) and Scheurich (1994) as a way to counterbalance the positivist approaches in policy making. Policy archaeology is introduced as a way to increase political reflexivity, where democratic emancipation of human potential and human dignity serve as principles for political adjudication to complement those of effectiveness and efficiency.

On the normative side of the debate, I also introduce the delicate issue of bureaucrats "speaking truth to power." In deconstructing the relationship between truth and power, I attempt a way forward by clearly demarcating the decision-making responsibility of the elected official in government and the bureaucrat undertaking the policy-making work. This chapter concludes that a standardized and consistent practice on the account of elected officials, bureaucrats, and researchers is most likely to result in democratic ends being achieved. The need for the development and establishment of international standards of best practice in policy making, as well as the encouragement of a healthy challenge function to policy directions being entertained, is identified. The chapter concludes with a list of best practices identified by Pal (2001) that can serve as a starting point for discussion with policy makers. Thus, this chapter introduces social and political theorizing not as a substitute for research and reform, but as a supplement to increase the level of reflexive debate in addressing policy issues. I am in no way suggesting that the normative position expressed here or my own social theoretical understanding of the way the state, society, and knowledge production intersect with each other is without contestation. It most certainly is; however, as best practice I am suggesting that a potential way forward on the practical front requires thinking about such matters in an intellectually disciplined way, and what I expect of others, I should also expect of myself.

Social theory of knowledge and the state

Armed with the social theory of knowledge developed to this point, I believe that the question that arises is what the appropriate role of the state is in "managing" knowledge for health care policy making. Knowledge in its various forms, ideas, opinions, ideology, values, and scientific evidence is socially constructed. The pursuit of a capital *T* truth through a positivistic approach is demonstrated to be futile. In the words of Miller and Fox (2001),

> The notion that we can formulate universal rules for accepting or rejecting a theory is now more nostalgic than useful. Strict adherence to the positivist protocol, which falsely presumes the soundness of correspondence theory, will not produce truer and truer results. Mechanical procedure must yield to context. (Miller et al., 2001, p, 682)

In a liberal democratic pluralistic society, an approximation of the truth is more likely to be advanced through the meaningful discourse and contribution of the social sciences and qualitative methods as a complement to the quantitative sciences. If ideology is a socially constructed set of ideas that facilitate one group or groups dominating over others through social norms, a question must be raised as to whether the dominance may be detrimental to the health status of a marginalized group or society at large. The principle being promulgated in this argument is that all individuals in society ought to have an equal opportunity for emancipation in reaching their potential regardless of age, sex, gender, race, ethnic background, or state of health. In most democratic liberal societies, the health of an individual, group, or society is not considered a commodity: rather, it is a public good. Ideas in the form of ideology, values, opinions, and scientific evidence should not serve as barriers to good health in individuals or populations as a whole. It is a natural condition in society for epistemic communities to protect and maintain their positions of material privilege and power. This project attempts to describe a way forward that disarms the unfair domination of ideology, values, opinion, or scientific evidence where it is not in the best interest of the health of individuals, marginalized groups, or the population. Having established these premises, how are we to deal with the question of the appropriate and necessary role of the state in advancing politics and policy making in health care that benefits individuals and population health?

Influences from abroad

Canadians are fond of their publicly funded and universally accessible health care system, as was confirmed by the Commission on the Future of Health Care in Canada. It is one of the most cherished and important differentiating features Canadians point to between Canada and the United States. Maude Barlow, the national chairperson of the Council of Canadians, Canada's largest public advocacy organization, states, "We Canadians treasure our universal health care system. Polls consistently confirm that, no matter what turns the economy is taking or where the political winds are blowing, support for this core foundation of Canadian society never wavers" (Barlow, 2002, p. 1). Why, if universal health care is so revered in Canada, do public debates around rights of access abound?

After developing such a universally accessible and relatively comprehensive health system, how did Canada enter into the contemporary debate as to the appropriate role of the state in delivering and financing health care? Some of the first influences in Canada materialized with the elected government of Alberta, which, under Premier Klein's leadership, was looking toward Thatcherism in the United Kingdom, Reaganomics in the United States, and the state policy of Douglas in New Zealand (Cooper & Kanji, 2000, p. 56) to inform government policy to ostensibly bring public expenditures under control. The World Bank released the *World Development Report 1993: Investing in Health*, which, on the one hand, paid homage to the importance of public financing of health care services, but on the other, introduced the idea of competition as a necessary complement to stimulate involvement of the private sector in order to bring costs under control. The report recommends that states facilitate involvement by the private sector and consider policy change to do the following:

- Encourage private finance and provision of insurance (with incentives to contain costs) for all discretionary clinical services.
- Encourage private sector delivery of clinical services (including those that are publicly financed).
- Provide information on performance and cost. (World Bank, 1993, p. 14)

The problems and issues experienced in Canada were arising similarly in the Organisation for Economic Co-operation and Development (OECD) countries of Europe. European countries were exploring the ingredients that would help resuscitate their ailing health care systems. Experiments embarking on market-oriented incentives were being introduced in Western Europe during the 1990s. In a summary of the European health care reforms during the 1990s, the following observation was noted in a publication of the World Health Organization:

> The role of the state in the health sector is becoming one of strategic planning, monitoring, outcome-oriented regulation and, where appropriate, designing particular subsector markets for service providers. To adapt a metaphor used by public policy analysts, the state is learning to do "more steering and less rowing" on the supply side of the health sector. (Saltman & Figueras, 1997, 275)

These forces, along with other neoliberal influences, were impacting on the emerging public debate in Canada on the future role of the state in health reform. Alberta and Saskatchewan provided an example of two provinces adjacent in geography but divergent in their exploration of public policy approaches – one looking toward rightist market-oriented solutions and the other toward leftist communitarian values.

The state and individual liberty

The dichotomization of public policy approaches in Alberta and Saskatchewan can be situated within the context of a much broader question of what the appropriate role and authority of the state are in relation to the individual in the liberal democratic society. Questions arise around this relationship, which have a moral and political dimension. Carmichael (1985) provides us with a convenient framework by which to think about these issues (Carmichael, 1985, p. 60-90). Morally, the questions that arise are about how one ought to live, what the good life is, what one's duties to others are, what we owe others, and to which authorities we submit. Politically, the answers to the questions are about values (freedom, security, etc.) that will be promulgated by the state's laws and policies. The answers citizens give to these questions express that person's values. A people's values can be assessed. For example, do people believe the disadvantaged should be suppressed or do they support their achieving their human potential?

According to liberal egalitarian principles, an individual expressing value of reaching their potential regardless of race will have more highly developed values than someone who espouses values of segregation in which one race dominates another. Individual values may accumulate to represent the community values and they become a mosaic of heterogeneous values.

Values, however, are not the only things that drive policy. Rights and interests also drive policy. The establishment of a legislated right to equal access for health care spawns policy responses and facilitates universal access to health care services regardless of race, gender, social class, or religion. The Commission on the Future of Health Care in Canada, which was cited in the previous chapter, identified values as a core constituent at the heart of the health care system; nevertheless, rights and interests play a secondary and complementary role.

> In their discussions with me, Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity. These values are tied to their understanding of citizenship (Commission on the future of health care in Canada, 2002, p. xvi).

In articulating this position, the former Premier of Saskatchewan was highlighting and legitimizing the fundamental principles of social justice as the policy framework for health care services in the country.

Individual liberty, democratic authority, and social justice

A Western industrialized liberal democracy is founded on three fundamental principles: individual liberty, democratic authority (authority derived from a duly elected government), and the conflation of these two principles into social justice for the individual within the larger community (Carmichael, 1985, p. 78). In a liberal democracy, there is a constant tension between two contradictory principles: individual liberty on the one hand and democratic authority on the other. The relationship between the two is direct and inverse – as individual liberty increases, social authority (control of the state over the individual) decreases and vice versa. This dichotomy was effectively captured on the Gibbins and Youngman (1996) model described earlier. How does one successfully mediate between the rights of the individual and the needs of the community? Authority is the right to rule others, a right, if legitimate, we ought to obey. This authority arises from the political association that the citizens have democratically exercised and is conferred as legitimacy onto the state in the form of government. Legitimacy becomes problematic when issues arise that intervene between commitments that are individualist versus collectivist. As we promote the interests of the majority, we invade the rights of the individual. Liberal democracies thrive on a healthy dynamic tension between a continual questioning of the state's authority and maximizing the individual's freedom. The degree to which a liberal democratic state is successful can be measured by looking at (a) the degree of general welfare, for example, the health status of the population; (b) the degree to which human rights are exercised (these may be negative rights, for example, to be protected from crime, or positive, such as access to a public good like health care); and (c) the opportunity for individuals to reach human excellence (Carmichael, 1985, p. 60 - 90). These principles are easy to articulate but in practice, real-life issues are embroiled in complex tradeoffs among the principles. These tradeoffs may result in policies that the state promulgates to the advantage of some groups in society and the detriment of others. Drawing the proper line between claims of individual liberty and those of social authority is one major challenge. In Alberta, it seems that an individual's economic choice of access to health care services, where the marketplace complements the public health care system, is more important than it is in Saskatchewan, where social responsibility and access seem to be emphasized.

Emergence of ideology as a factor

The state's role in the financing and delivery of health care to Canadians arises as a positive right owing more to republican rather than to liberal theories of the state. This sense of a public community originates in the conservative and socialist traditions more evidently in Canada, than, for example, the United States. The narrative history and social historical development of communitarian emphasis will be reviewed in the next chapter. It is legislation and policy that restricts individual liberty in the name of their own welfare through such actions as restricting who can practise medicine and what drugs can be sold or included in the provincial drug formulary. This legislation is paternalistic and justified on the basis of protecting the individual by adopting a community standard of morality or human dignity. Unrestricted access to health care has come to be a citizen's entitlement in Canada, something that is owed to the citizen as a duty of others. It is from this dynamic configuration that political ideology begins to surface in political reform. To what extent should the state intervene in the provision of a human service? Traditional liberalism and free enterprise conservatism support negative rights and deny positive rights in principle – no one is owed anything by the state whose sole role is to control people's negative rights (Carmichael, 1985, pp. 88-89). Those who cannot afford health care should look to private charity. Those who cannot afford private protection and security from crime should consider a feudal arrangement with someone of means. At the other end of the spectrum are those who argue that all rights to goods and services required for a dignified life should be provided by the state. Positive rights are entitlements of citizens. Between these two notions of "libertarian rights" and "republican citizenship," the reality of Canadian politics and policy plays itself out in respect to the kind of health care Canadians feel entitled to. The emergence of political ideology, to complement or compete with individual values, as a key factor influencing the approach a state takes to health care delivery and funding enters the public policy realm.

"Finding the balance" in the role of the state

The Canadian academic and research community, as the intellectual elite in knowledge production, appears to have arrived at a consensus on the philosophical foundations for health care policy in Canada. The "research community" came together on a number of occasions to deliberate on how they might make a positive contribution toward the development of a "healthy policy" for Canadians. In 1989 at Queen's University in Kingston, participants attended a conference entitled *Healthy Populace, Healthy Policy – Medicare Toward the Year 2000*. The theme of the program implied that with the introduction of appropriate policies, the treasured health care system would continue to evolve progressively to the new century. The organizers of a follow-up conference at Queen's in 1992 in retrospect recognized just how naive their approach in 1989 was. The title of the conference was *Health Care Innovation, Impact and Challenge* in recognition that coming up with policies was only half of the challenge. Another part of the challenge was their successful and prudently exercised implementation (Davis, 1992). Policy implementation has emerged as an important and significant player in policy analysis (Sabatier, 1986). In 1996, a conference was held at Queen's under the banner *How Many Roads...? Regionalization & Decentralization in Health Care.* The conference highlighted that each province had embarked on regionalization and reform in a different way. One province, Ontario, embarked on a process entirely different from the other provinces, a full restructuring of their health care services. Enough experience was being gained from the different approaches that participants began to examine and compare the international experience with regionalization and lessons appropriate for the Canadian context (Dorland & Davis, 1996).

In addition to the work in university academic research settings, knowledge production was also situated in the growing and influential think tanks in Canada (Abelson, 2002). These think tanks tend to be "right" leaning and push neoliberal approaches to the funding and delivery of health care services (Carroll & Shaw, 2001). Riding the crest of the wave of interest in exploring market solutions in health care reform, the Institute for Research on Public Policy (IRPP) in Montreal, in conjunction with the Brookings Institution in Washington D.C., organized a conference titled *Roundtable on Health Care* in Montreal in May 1994. The organizers of the conference, in the introduction to the proceedings, point out that two researchers looking at the same experience – British National Health Service reforms – come to two different conclusions! "Glennerster believes that the reforms have been a useful step forward, while Maynard finds them to be mostly misconceived. The whole idea of an internal market can vary according to the standpoint of the country. In Sweden, it can be seen as serving to expand choice. In the US, the most controversial element might be imposing a budget" (Jerome-Forget, White, & Wiener, 1995, p. 16). The diversity of points of view for the appropriate role of markets in health care increased, as did the crescendo of the debate.

A pragmatic approach to studying the issues was undertaken in 1991 by the Economic Council of Canada, which launched a project in response to the recommendations of the numerous provincial royal commissions and task forces of the 1980s, encouraging the development and use of studies and models of cost-effectiveness to inform the issue of the future sustainability of the health care systems in Canada. During the course of the project, the Economic Council of Canada was disbanded and the project was transferred to the University of Ottawa. The outcome of the project was a synthesis report examining the health care sector through a system-wide lens, identifying links between health care and health from which to draw conclusions about making health care sustainable. The project also identified some innovative initiatives in several provinces that might serve as benchmarks for better practice (Angus, Auer, Cloutier, & Albert, 1995). The question of containing health care costs was an issue in all provinces in Canada during the 1980s and 1990s, but the issue of the future sustainability of the health care system over the longer term arose specifically in Alberta. This fuelled a further debate as to whether in fact there was enough money allocated to health care as a proportion of provincial revenues or whether it truly was going to eventually gobble up all government revenues.

The nature and functioning of knowledge production (Fuller, 2002b) and the important role of intellectual elites situated in universities and think tanks (Abelson, 2002) highlights an important element of this thesis – the politics of knowledge production (Peterson, 1996) and the contestation of what counts as legitimate knowledge (Fuller, 2002a). Questions and issues surrounding the role of knowledge in a society (Etzkowitz et al., 1998) and the role of the state in "managing" knowledge has increased in importance in the last two decades (Stehr, 2002). Which intellectual elites from academia, think tanks. or industry (Etzkowitz et al., 1998) will have the opportunity to inform the policy debate? How will their opinions be adjudicated? Will the disciplines from the clinical sciences dominate the policy agenda or will the views and ideas of those in the social sciences and humanities (Willinsky, 2000) be sought as well (Fuller, 2002a)? How will the merits of the various forms of evidence be adjudicated (Fuller, 2000)? What is the role of knowledge producers and public pedagogy in health care reform (Kachur, 1999)?

One way of finding the balance is through the notion of deliberative democracy. C. Cohen (1999) states that "deliberative democracy is rooted in the intuitive ideal of a democratic association in which the justification of the terms and conditions of association proceeds through public argument and reasoning among equal citizens (Cohen, 1999a, p. 72). Like C. Cohen, Benhabib (2002) describes deliberative democracy as an ideal that democratic institutions ought to strive for as "a necessary condition for attaining legitimacy and rationality with regard to collective decision making" (Benhabib, 2002, p. 69). This model of deliberative democracy (Abelson et al., 2003) is contrasted to that of the liberal social choice theory in which citizens compete to further their interests through the democratic institutions (Cunningham, 2002). This project aligns itself with the deliberative democracy tradition as a way to mitigate the policy debate between values and scientific evidence.

Private versus public funding of health care emerges

In 1995, the Regional Centre for Health Promotion and Community Studies at the University of Lethbridge sponsored a conference in Alberta titled *Efficiency vs. Equality: Health Reform in Canada.* The proceedings of the conference caution about simple solutions to what are complicated and interrelated problems and issues (Stingl & Wilson, 1996). The conference encouraged a judicious balance of fiscal reform and social reform to achieve efficiency and equity in health care policy.

The Fraser Institute, on the other hand, identified a three-pronged strategy that would set the stage for successful reform of Canada's health care system. The Fraser Institute's solution consisted of the regional purchasing agency concept being brought to the purchasing of hospital services, which would separate the purchaser and provider, thereby introducing competition to the system. A second thrust was to see hospitals privatized to bring the benefits of private sector management into their administration, finally recommending that "the system must be structured in such a way as to permit private and public sector facilities to compete on a basis of equality for the right to provide service to both public and private sector patients" (McArthur, Ramsay, & Walker, 1996, p. 30).

The previous two approaches crystallized the debate that was emerging in Alberta about the role of private funding in the Alberta health care system. The ideas promulgated by the Fraser Institute's book *Healthy Incentives: Canadian Health Reform in an International Context* ignited a storm of controversy as the Friends of Medicare, opposed to any private ownership of hospitals, began to mount a campaign in opposition to the "privatization" of health care. The distinction that was often lost in this debate was that of private versus public funding and private versus public delivery of health care. This was a blur that the health care unions that supported the Friends of Medicare did not mind. For example, a health authority could contract out surgical services to a private fee-for-service group of physicians in a private surgical facility; however, those services would be paid for publicly and access to the service would not be restricted by the ability to pay. This arrangement was no different than visiting a family physician in his private office. This distinction was lost on citizens who were suspicious that governments were looking to offload the costs of health care.

Monique Jerome-Forget and Claude Forget, writing on behalf of the think tank IRPP, developed a blueprint for Canadian health care reform in a book they published in 1998. The authors maintain that an advance market mechanism must be introduced in Canada to facilitate a more efficient match between supply and demand, ensuring the fairness and accountability of health care services to Canadians. The mechanism they propose is the "Targeted Medical Agency" whose role would be to have doctors establish their publicly funded budgets based on the number of patients who agree to sign up. The health needs of citizens would be delivered through the doctor or through services purchased from outside agencies by the doctor on behalf of the patient (Jerome-Forget & Forget, 1998, pp. 93-122). As characterized to this point, the views on how the market could help resolve issues of funding and delivery of health care services were as divergent as the think tanks and agencies themselves. All were working from their specific premises and ideologies as to how the market could contribute to resolving the issues, and all claimed to call on selected evidence that supported their particular approach. What was lacking in the public debate was any differentiation of which evidence was worthy of consideration and which was not. By extension, the same questions could be asked of which values and ideology would contribute to improved public health.

In an effort to consolidate the thinking and reflect on developments in Canada, Daniel Drache, the Director of the Robarts Centre for Canadian Studies at York University, and Terry Sullivan, the President of the Institute for Work and Health in Toronto, organized a seminar in 1996 entitled "Reforming Canada's Health Care System." The outcome of the seminar was a book on market limits in health reform, which explored the tensions between a publicly funded health care system and the dynamics of markets in the delivery of privately financed health care (Drache & Terry, 1999). The stage came to be set for the dynamic interplay of evidence, values, ideology, and opinions in the making of health care policy in Canada.

How are we to deconstruct the implications of the debate surrounding health reform on the appropriate role of the state? The remainder of this section will describe an approach that will help disentangle how the state might effectively approach the challenges of policy making for health reform.

A way forward: Problematizing health care policy making

Thomas Osborne (1998) provides one way out in a paper entitled "Of Health and Statecraft." (Osborne, 1998). Speaking of the work of Foucault, Osborne writes, "He offers no positive conceptions as to how health might be regulated, only historical studies relating to how systems of knowledge concerning the health of populations came to be linked to styles of power and procedures of state" (Osborne, 1998, p. 173). Having articulated this view, Osborne goes on to describe how Foucault's perspective can help clarify the relationship among health, health care, and the role of the state. Osborne identifies three forms of "reactive" approaches to health policy – meliorist, critical, and antimedical.

The reactive stance to policy analysis describes how policy is a reaction to the "objective" problems of the health needs of citizens and how the state may respond in the services to be delivered. The meliorist approach characterizes health policy as the progressive improvement of health knowledge in overcoming obstacles to knowledge and limitations in service. As these challenges are overcome, new health problems arise. Health policy is viewed as progressive in response to problems arising in the community. The critical approach identifies not only the objective problems, but also the myriad of interest group interactions and intergovernmental conflicts that are negotiated into a policy solution for the state. Progress in this approach is based on the distance between the stated objectives, negotiated solutions, and resulting progress or lack of progress identified. The antimedical approach (often ascribed to Foucault), considers that an objective identification of problems is not possible, that health policy constructs its issues, and that health problems are relative within their own local contexts (Osborne, 1998). That the common approaches are reactive will be borne out in our review of the work of Meilicke and Storch (1980), Torrance (1998), and Taylor (1978) in the following chapter.

If an approach to policy and its analysis is not reactive, what can it be? Osborne (1998), on the basis of Foucault's work, would suggest that policy development could be creative in the form of problematizations. Problematizations are different from reactive constructs because reactive constructs reduce complexity and provide a field of delimitation, regulating what can and cannot be said. Those undertaking research activities know that the way that a problem is articulated influences strongly the solution that will be found to that problem. Osborne, referring to Foucault states:

> Government does not just specify the subjects of governments as being agents passive before power but as monads of conduct, whose conduct can be shaped in various ways and directions. Government, in other words, always tends to problematize – to put into question – the relation between those who are governed and those who govern; problematizations of government are also questionings of the very objects, means and ends of government. (Osborne, 1998, p. 175)

According to this approach, states are best informed in their policy actions when they intelligently problematize an issue. The question arises as to what evidence or objects of evidence are used to problematize an issue. Steering away from a reactive approach, discussion could turn to the constitution of professional authority (or best practice), rather than private interests, and to the establishment of norms and styles of governing, rather than solely legislation. Redirecting the focus from institutions of government to practices of government helps to inform one of the collections of practices that constitute governmental reasoning. The concepts of using HQE, informed opinions, positive values, and ideology to in turn inform a best practice of governmental reasoning or policy making arise from the approach and are implicated in their politics and reflexivity in the ongoing struggle for reform. In other words, knowledge production does not provide a "God's eye view" by which to judge political reform, but rather, is implicated in the very politics of reform as both a self-interested party to politics and a means to provide reflexivity on key issues of legitimate knowledge (Kachur, 1999).

In an attempt to explain the relationship between public pedagogy and policy making in the field of education, Kachur (1999) examined the process that the Alberta government undertook to build consensus during the Alberta Growth Summit in 1997. Kachur looked "at the 'stakeholder' consultation process as the vehicle whereby dominant social groups create a broad-based alliance and establish a system of 'permanent consent' that justifies the existing social order and *increases inequality, while claiming to do the opposite"* (Kachur, 1999, p. 60).

The challenges of disentangling the governmentality or governmental reasoning in Alberta and Saskatchewan around the practice of health care policy making is a key focus of this project. It requires a research strategy that understands both the politics of social science and biomedical research communities as implicated in the politics of reform. The research community is only one player of many in public health reform and the promotion of competing practical knowledge originating in competing epistemic communities, in this case, politicians, policy makers, and citizen elites. How can the research strategy for this project be advanced without falling victim to an unsuspecting bias of one of the epistemic community's perspectives or interests?

Can policy archaeology help health care policy making?

Scheurich (1994), also following the work of Foucault, has developed an approach called policy archaeology, which focuses on the social construction of social problems in an effort to better understand policy studies in education without being captured by the definition of the social problems and debates of policy makers. In Scheurich's words, "policy archaeology studies the numerous, complex strands and traces of social problems prior to their naming as social problems." (Scheurich, 1994, p. 300). Scheurich examines the naming process, the process by which problems enter the gaze of the state and policy researchers. Scheurich divides policy archaeology into four arenas of study:

- The study of the social construction of social problems
- The identification of the network of social regularities (categories of thought and ways of thinking) across social problems
- The study of the social construction of the range of acceptable policy solutions
- The study of the social functions of policy studies itself (Scheurich, 1994, p. 300)

Scheurich amplifies four points about the second arena:

1. The regularities are not intentional – agents did not consciously create them, although they may benefit from them and wish to maintain them. If agents do not create them, how do they arise? Scheurich draws from Foucault to explain that they are an emergent and regenerative character of society.
2. An important distinction needs to be made between the social regularities that are visible, and empirically validated, and that should not be confused with or mistaken for being or creating the material reality.
3. Regularities are framed within their historical context and policy archaeology, as a method for identifying them within that historical period is emergent.
4. Policy archaeology moves against structuralism, positing instead a fusion of the deeper structures and surface behaviour of agents. (Scheurich, 1994, pp. 302-303)

Having the tools identified in the previous chapter for deconstructing and understanding the ideology and values circulating around health policy issues will provide a tangible way forward to problematize the essence of health care issues that arise in society. The insights drawn from Osborne's (1998) and Scheurich's (1994) work will be instrumental in developing best practices for policy makers who will be required to problematize and deconstruct the interplay between and among ideology, values, opinions, and HQE that are used to inform health reform policy making in Alberta and Saskatchewan between 1987 and 2003.

Clarifying the role of the state in health policy making

How do Osborne's (1998) and Scheurich's (1994) approaches help inform the quest to clarify the relationship of the role of the state and health policy? The reviews of the historical development of health care in Canada in the following chapter will illustrate how the state came to take on more and more responsibility for the welfare of its citizens. In its early history, the welfare of citizens did not figure as prominently as it does today. This is illustrated in 1942 by the Canadian Federation of Agriculture, who in a booklet entitled *Health on the March*, state "Health is moving rapidly from the field of thinking of a service or a charity for some to be given by the better privileged to others…into the field on thinking of it as an integral part of the life of every Canadian. In other words, the people are thinking of health as a right of citizenship, of even greater importance than education or police protection, which are taken for granted" (Taylor, 1978, p. 33).

Osborne (1998) traces the increasing responsibility of the state for its citizens to two sources. The first is the German mercantilist doctrine "science of police" (medical police) from which the word *policy* derives. Osborne, building on the work of Rosen (Rosen, 1953), writes, "According to the linked doctrine of cameralism, the population – its health, wealth and longevity – becomes the greatest resource of the power of the state" (Osborne, 1998, p. 177). In this approach, all government policy was related in some way to the population's health. This concept has remained an ideal; however, it did have an unsavoury aspect to it during the terror inflicted by the Nazis (Lifton, 1986) and the totalitarianism of Stalin. Parallel but contrasted to the German approach was that of the French, who juxtaposed the duty of government to secure the well-being of its citizens with a "reversal" of the power relationship to a right for citizens to be provided with health and well-being. Physicians during the French Revolution incorporated the concept of the social contract between citizens and the state into their theory of public health (Osborne, 1998, p. 178).

The contrasted German and French approaches assume or imbue a determinate relationship between the activity of the state and its citizens, the former a compulsory health and the latter something that can be demanded from the state. In one case, health is an instrument of the state; in the other, the state is an instrument of health. The purported determinacy of the relationship suggests that doing something at one end (allocating funds for magnetic resonance imaging [MRI]) results in something at the other end (improved health). Our contemporary problems are, however, characterized by the indeterminancy of this relationship. We really do not know very much about which health care interventions are making the biggest difference in improving the health care status of the population. More dollars for more open-heart surgeries are not necessarily resulting in improved health of the citizens. There are interests in the health care system that would like to preserve the traditional causal associations of intervention (more MRI) for increasing health, even if the opportunity cost is forgoing other state interventions that may be more effective in improving health status. Politicians, policy makers, researchers, providers, and citizen have to wade into the debate. Which evidence, values, ideology, and opinions will be taken into account and have a marked impact on the policies to be forged?

What are the implications of the indeterminancy of the relationship between health and health policy for the role of the state? Fundamentally, this means that health cannot be a direct aspect of citizenship but rather an indirect one. States can put in place structures and processes to help ameliorate and mitigate ill health, but they cannot guarantee health. It is to some extent a matter of fate, a concept analyzed in detail by Visser (Visser, 2002). Health is also an ideal that is impossible to achieve or define – it is in fact the absence of disease that people refer to. Just as sanitation and clean water supply were once groundbreaking public policy initiatives, today they are taken for granted and replaced by heart disease and cancer as the primary health issues. Ideal health policy, like health, can never be achieved – the targets of reducing the burden of illness are before us and as soon as they are achieved, new challenges (norms) will arise. Regimes that have attempted to invoke health as an ideal objective of their policy have quickly reverted the idea of health being a right of citizenship to that of it being a duty of citizenship (Osborne, 1998, p.

180). Positing health as an ideal concept marginalizes those who are diseased or disabled, a deviation from the norm. "If health policy is to embody a concern for the normativity of life, then it will have to acknowledge, surely, a certain modesty of approach" (Osborne, 1998, p. 181). This revelation causes the mediating instruments of technology (originating from the Greek *techne*) of health care policy to become the focus of our attention. How are they used? Whom do they impact? Is individual autonomy preserved in the mediation? Issues surrounding health care policy may be best informed, according to Osborne, through "historical fieldwork of problematizations in technologies of health; and a question perhaps, of attempting to tie such technologies to wider political rationalities of government" (Osborne, 1998, p. 181). It is this challenge that this project undertakes: to identify, describe, and analyze the "political rationalities of government" in Alberta and Saskatchewan from 1987 to 2003 in approaching health care reform.

Epistemic communities and health care policy making

Contrasted to the Greek word *techne* is the word *episteme*, which is translated as knowledge. Foucault used *episteme* to describe the normative linguistic structure of a discipline. Epistemic communities, as identified earlier, arise from a shared set of normative and principled beliefs serving as a value-based rationale for social action of community members. The epistemic community shares a common policy enterprise with a set of causal beliefs derived from their studies of problems and issues, which describe linkages between possible policy actions and preferred outcomes. The epistemic community also shares an understanding of validity with internally defined criteria for weighing and validating knowledge in their field (Haas, 1992, pp. 1 - 35). Miller and Fox (2001) observe, "...the cultural practices and linguistic structures (ground) of the epistemic community both imprison and enable us, delimiting what is feasible, what is possible, and what is pertinent (Miller et al., 2001, p. 683). Drawing a connection to the work of Archer (2000), it becomes clear that the think tanks and anonymous intellectuals[3] become the syncretic instruments through which competitive and constraining contradictions in the discursive, and in some cases practical, knowledge come to be resolved (or not) as the material culture seeks to preserve the status quo through the discursive relations with the propositional culture.

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[3] The use of anonymous intellectual derives from Kachur (2002), who defines it as "the voice that 'speaks' anonymously as a 'divinity' through the production of unauthored texts...the charismatic authority of the intelligentsia indicated by their privilege and prestige to profess on issues of fact, value and taste (Kachur, 2002, p. 323).

The four epistemic communities of interest in this project – politicians, policy makers, researchers, and citizens – mediate and reconfigure the influence of new knowledge on the health reform direction. The interviews with the informants attempted to determine to what extent the epistemic communities (core and extended) shared common ideas among themselves and compared with the other communities, and whether they shared normative beliefs about what policy-making alternatives should be examined and toward what outcomes.

The characteristics of epistemic communities as described by Haas (1992) have relevance for identifying and explaining the emergence of numerous think tanks, which have populated the Canadian landscape in response to new issues and problems (Carroll et al., 2001) in the Canadian health care system (Abelson, 2002). According to Haas, epistemic communities emerge when uncertainty arises from the way forward in policy direction. Policy makers turn to epistemic communities for advice to ameliorate the uncertainty by having them interpret and formulate courses of policy action. If the need for the information continues, epistemic communities may become institutionalized. The Fraser Institute emerged, for example, as part of the neoconservative trend for policy solutions that came from the post-Reagan and Thatcher influences.

Linked to the rise of epistemic communities, Kachur (1995) undertakes to analyze and explain how and through what mechanisms of ideological production hegemony is exercised in the contemporary period in Canada. Kachur (1995) writes, "This rightist revolution is scientifically legitimated by intellectual practitioners who produce what I label corporatist postmodernization theory and is being politically secured by what I label anonymous intellectual practice" (Kachur, 1995, p. 4). Kachur (1995) captures this dynamic in the following description.

> Understanding the nature of the interplay between both the theory of postmodernization and the method of the anonymous intellectual is crucial for understanding the new hegemony which is displacing the social relations of the capitalist welfare state. This new hegemonic strategy is an ominous challenge to freedom and democracy in the name of "freedom" and "democracy" by the pedagogues of "scientific management," "libertarianism" and "corporatism....As new knowledge is catalogued and collated into cross-impact analyses, decision trees, scenarios, simulations and computer models, the knowledge emerges as a cultural commodity, written up to appeal to policy makers and corporations as profitable information resources to help plan and create a preferable future. One important question is left begging though: whose preferences are being served? (Kachur, 1995, p. 5)

Kachur's insights (Kachur, 2002) into these emerging dynamics will serve as an important lens through which this study will examine what are to be the evidence, values, ideology, and opinions used to inform health care policy making and whose interest(s) they serve. How is it that the epistemic communities of politicians, policy makers, researchers, and citizens articulate and engage their perspectives into the dynamics of policy making?

The right to health care in Canada: A right in transition

The relationship between citizenship and the right to health care was underscored as an important value to Canadians (Commission on the future of health care in Canada, 2002). This relationship has been studied by Redden (2002). Although the validity of rights has a weak philosophical foundation, Redden finds the concept well embedded in the Canadian political reality. Redden maps the historic trajectory:

> ... claims to the right to health care in the 1940s translated as: the "just expectation" that medical services would be made available to the entire Canadian population through a combination of private and public insurance programs. By 1960, the right had come to present the expectation that the latest medical technology would be distributed universally, an expectation that embodied the communal nature of rights as normative statements of ought and identity (health care ought to be distributed as a public good, and the universal distribution of health services reveals how Canadians do things). By 1990, the intention of rights claiming had changed completely, and had become more intensely individualistic. (Redden, 2002, p. 117)

Redden (2002) attributes the change in rights culture during the 1990s to three emergent forces: (a) the rhetoric of the "marketization of the state," trading citizens' "political empowerment" for "economic empowerment" in health care in the face of states' declining ability to provide during a period of declining fiscal capacity; (b) the dual emphasis of individual/legal rights and collective identities arising from the 1982 Canadian Charter of Rights and Freedoms, leading to the "recognition that the promise of equality (sameness of status) from universally available social programmes is somewhat out moded in the context of differentiated citizenship" (Redden, 2002, p. 122); and (c) the Canada Health Act of 1984, which concretized the role of the state in health care (Redden, 2002, pp. 117 - 118). Supporting the three dynamics, observes Redden, were the increasing expectations of Canadians, on the one hand, and on the other, a sharpening of the states intention to

> ... provide publicly the benefits of medical advancements to the entire Canadian population...by virtue of consumer power or as a matter of individual legal compensation, citizens are entitled to services because they have purchased them in advance through their taxes, or simply have legitimate and legally enforceable claims against the state. (Redden, 2002, p. 118)

These trends led Redden (2002) to assert, "If citizenship arrangements already are moving in the direction of fractured patterns of entitlement for cultural communities, then it makes sense for health care, as one of the primary benefits of Canadian citizenship, to follow the same pattern" (Redden, 2002, p. 124). The contemporary political transformation of the right to health care may be better served by pursuing health reform through differentiated models of citizenship than through legal rights. It would be useful for a moment to explore what differentiated models of citizenship may mean in a practical sense in Canadian health care policy making.

The first question to be answered is how a judicious, appropriate, and effective health policy is to be developed. Osborne (1998) identifies two approaches: the liberal and neoliberal. The liberal approach to health does not act on health itself but by regulating techniques in the environment. Hospitals are constructed, surgeries are performed, and instruments of delivery are offered the public. A neoliberal approach to health "acts directly upon health by giving the ideal of health a series of surrogate values, entailing a sort of constructivism of goals and targets intended to bring about strategically limited objectives" (Osborne, 1998, p. 181). This observation is confirmed in the repeated recommendations of contemporary task forces and commissions that speak to greater accountability to performance measures in the health care system. Setting targets, goals, or outcomes, such as decreasing the number of newborns who weigh less than 1,000 g, is an example of this. Embarking on efforts that will cause this number to fall – focusing on expectant mothers who are not looking after their health – identifies the differentiated citizens that Redden has identified as those who would be beneficiaries of a state-provided service.

The neoliberal approach to making health care policy introduces a new set of solutions that in turn spawn a new set of problems that Canadians may wish they had never started to tackle. Theoretically, the logical extension of a state working toward the reduction of morbidity and mortality in a society may be directed toward the elimination of morbidity and mortality. Achieving immortality may well be desirable for all individuals in society, but at what cost? Technologically, it may be conceivable that with organ transplants and mechanical implants we can keep the human body alive forever – but at what cost and at what opportunity cost? The fact that resources are not infinite limitations on where society chooses to invest in health care and how it chooses to measure progress through surrogate measures of health begins to illustrate how the dynamic interplay of evidence, values, ideology, and opinions come to be very important as to what policy choices are made for citizens.

Pursuing the truth in health policy making

Having identified the logical extension of an extreme form of neoliberal interpretation of what might constitute human health in a society, how does one identify the appropriate goals or targets for the state to pursue on behalf of its citizens? Osborne (1998) makes a link between the state's provision of health and the pursuit of truth when it comes to norms of the community and the body. "What the state must do is not to dictate the norms of health in the interests of government, but to regulate the production of truth by governing not health itself but those who are delegated to speak in the name of health, that is, the medical profession" (Osborne, 1998, p. 182). The responsibility is given to health professionals (physicians) to determine what mediating efforts ought to be undertaken to improve the health of the community. In the current neoliberal state, the approach is to introduce technologies that instrumentalize health policy: waiting lists, audits, clinical trials, and the use of quality-of-life measures. A second approach is what Osborne refers to as "responsibilisation" or making individuals aware of their responsibility for health on the one hand but also in the policies that are created and decisions that are made. "Because health is not an absolute value, neo-liberal attempts to construct values according to a kind of immanent logic – it involves a kind of boot-strapping of surrogate health-values; targets are set, market-exchanges take place, performance is monitored, success and failure rates are measured, new targets are set, further market-exchanges take place…" (Osborne, 1998, p. 186). The development and institutionalization of the instrumentalization of health policy may create a new set of problems for the future. It may be that the focus on the proxies for health or measures of access to health care becomes the focus of those who deliver health care, losing sight of the caring process.

Osborne (1998) is searching for a mediating entity between the individual and the state and he feels that the medical profession is in the best position to act in the public interest because he does not see that as an appropriate role of government. Setting that argument aside for the moment, what Osborne incites is a situation where, in Archer's (2000) words, practice becomes prime. The medical profession, through its position of institutional power, has significant influence in society and one such influence may be the maintenance of the status quo in its particular interest. This is disturbing, as constraining and competitive contradictions between the curative and health promotion paradigms of health care delivery suggest that too little is being done in response to the latter. The alternative of turning the responsibility to policy makers to facilitate the paradigm shift toward health promotion is even more frightening because of a potential conflict between their preservation of their institutional or bureaucratic interests over the public interest. A collaborative way forward may be for the medical profession, which is demonstrating some changes in their discursive and practical knowledge with an inclination toward health promotion, along with other health care professions and the public, to find mechanisms of citizen participation and institutions of reflexive discourse, deliberative democracy for example, to move this agenda forward.

This raises the concern of how one can be confident that the manifestation of the "truth" that is identified by the health professionals as necessary to improve health is the real truth. In section 3 of the thesis, informants provide us with advice and data about how the "professionals" who Osborne (1998) speaks of have cloaked their self-interest in the "truth" in order to maintain or enhance their positions during the negotiations surrounding the health reform process. Do the maintenance and preservation of their positions of power and control become paramount to the public good? Can we trust those who Osborne claims have the interest of the public in mind? How is progress to be gauged? One way may be to watch the movement of those things, which once were necessities to sustain the health of citizens, now become goods accessed for pleasure or through privilege. Having safe and unfettered access to clean water in the Battlefords, Saskatchewan or in Walkerton, Ontario may be examples of public health taking a step backward. Should citizens not be able to rely on the state to provide clean drinking water? What responsibility do individuals have to ensure that the state is fulfilling its responsibilities?

In appreciating the complexity of health policy making, we may find it more useful to look at the broader health determinants of social welfare of citizens beyond health care delivery to such things as a safe water supply, healthy foods, education, a supportive family and community, shelter, exercise, and a rewarding form of employment. Policy-making processes around health care delivery can have significant impact on a population's health but a "bigger bang from the buck" may come from addressing the health determinants noted. How do we ensure that the "truth" that will truly benefit citizens and is regulated by the state is correct? How would we know?

Characterizing policy making

If the absolute truth (or even one approaching it) is elusive, what ought to be pursued by the democratic neoliberal state in health care policy making? And how can we improve the policy-making process so that it ensures that at least the best possible truth to improve the health status of a population, on the basis of health determinants, is not ignored or subverted by a government?

One place to start is to examine the panoply of health care policy-making scenarios that arise. Rudolf Klein (1995), in analyzing health reform in Europe, classified the variety of policy-making scenarios into six categories. The first he called Cleopatra's nose, in which health reform policy is an accident of history attributable to the naiveté of a newly elected government and the enthusiasm of an energetic, but inexperienced and idealistic, Minister. Second is the economic determinism version in which government faces a $2 billion deficit and has to take action to reduce expenditures. Third is the policy-learning version in which successful experiences and strategies elsewhere are used to lurch toward progress. Fourth, the policy soup version is a mixed bag of activity and experiences, which are close at hand and inform the policy. Fifth is the ideological outing version in which government feels confident enough to move forward with policy that matches their ideological platform. Sixth is the organizational predestination version, characterized in society by the dynamics and complexity of interest group activity driving them toward an end regardless of government's policy. The versions alone are incomplete; however, together they complement and help us "to understand different aspects of the policy making process" (Klein, 1995, p. 176). If the policy process can be this fragmented, how should we attempt to work at improving its practice to achieve positive population health benefits?

Taking the case of Alberta and Saskatchewan, as I show later in more detail, we can slot Alberta into being a variant of the ideological outing version and Saskatchewan a blend of economic determinism and ideological determinism. Knowing that this wide variety of approaches to policy making is possible in any state in the Western world begs for the question to be asked as to whether there should not be policy-making practice that is based on standards of best practice. The best practice could well change and be refined as practices and new knowledge accrete, but they provide a foundational gold standard of performance regardless of the policy-making scenario that arises in the state.

Best practice in policy making: An oxymoron?

Pal (2001) points out that it is difficult to have standards of "good policy" development in respect to specific programs and instruments. One informant, a policy maker, in the interviews for this project stated that best practice in policy making was neither possible nor necessary. The definition of what constitutes good policy making is often silent. Pal (2001) observes:

> There is usually agreement about broad objectives such as reducing poverty or crime but often-wide disagreements about the problem situation and the right way to tackle those perceived problems. But there is a growing agreement on one thing: effective and responsive policies (however defined) are not likely to arise from flawed policy processes. An effective policy process is no guarantee of quality outputs and outcomes, but it helps. (Pal, 2001, p. 340)

Pal (1997) characterizes the relationships between good and bad policy design with good and bad policy implementation in Table 14 (Pal, 1997, p. 146). States of misery and failure are those that policy makers ought to avoid, as illustrated in Table 14.

Table 14: Policy Design and Implementation

POLICY IMPLEMENTATION	**POLICY DESIGN**		
		Good	**Bad**
	Good	Success	Hope
	Bad	Failure	Misery

How do we achieve good policy design and implementation? Best practices in policy design and policy implementation are more likely to result in good policy making than in bad policy design and implementation. Each is equally important. Best practices in this context are considered to be "strategies that are consistently shown to be effective from the viewpoints of receptors and producers of policy research" (Canadian Population

Health Initiative & Canadian Institute for Health Information, 2002, p. 1). Pal (2001) suggests that in order to assure a greater probability of success in policy making, there is a greater need for benchmarking the policy development function to ensure that it meets recognized standards (Pal, 2001, p. 341). The best practice of bureaucrats responsible for policy making in health departments would encourage them to seek the best advice. Good advice based on good evidence, however, may run counter to the ideology or interests that are being articulated by the politicians. How does one reconcile the dissonance that is created when those in legislative authority having been duly elected by their citizens come into conflict with the policy advice that is most likely to benefit the public good?

Policy development, decision making, and speaking truth to power

Pal (2001) recommends separating the policy development function, which is the process of identifying and elaborating the policy issues, articulating solutions, and making recommendations, from the decision making. The decision making and choosing of options is a political process and is taken by the institutional apparatus from the cabinet to the legislature. Pal (2001) identifies three primary challenges to benchmarking the policy process. First, it is a mix of craft and science – craft by definition is difficult to improve through technique. Second, policy development often touches on politically sensitive issues and involves speaking "truth to power" in the sense that truth may have been sacrificed to power. There are, however, many conditions or social characteristics that are not amenable to interpretation because they exist as an empirical reality (e.g., the aging of the population or proportion of females in executive management positions). It is important, therefore, that the processes of problem identification rely on good interrogation techniques and all possible alternatives are considered; this cannot be primarily ideologically driven, at least not in the traditional sense of political ideologies. The third challenge is that policy development is only a part of the process that takes place between the government and the politicians; it also involves interest groups, the media, and citizens. Although my focus was on improving the communication between the four epistemic communities covered in this study, it will not be sufficient to limit the building of reflexive dialogical institutions to these four communities only. This process, with its characteristics and complexities, still flows from a general desire of governments to improve the policy development portion of the process (Pal, 2001, pp. 342 - 343). Pal (2001) is not alone in identifying these challenges. Donald Savoie (2003) observes:

> There are a number of important management issues in the sciences, but our concern here is with scientists' ability to present their findings unfiltered and untampered within the decision-making process – to speak scientific truth to political power. Political power can do what it wishes with scientific advice, because it is directly accountable to the public and has to live with the political consequences of its decisions. But senior bureaucrats should not tamper with scientific findings to make them more palatable to their superiors or to make the findings say what they do not say. (Savoie, 2003, p. 156)

With experience from the New Zealand State Services Commission, Bhatta (2002) describes how they established the key characteristics of an evidence-based, high-performance policy unit. The key characteristics were as follows:

- Chief executive commitment
- Rigorous and grounded analysis
- Effective quality assurance systems
- Positive stakeholder relations
- Maintaining and improving capability
- Continual monitoring and adjustment (Bhatta, 2002, p. 101)

What safeguards or best practices can policy makers rely on to facilitate the high-quality scientific evidence speaking truth to power? Pal (2001) identifies a series of initiatives that may not necessarily guarantee good policy design but would go some distance to contributing to it:

- Train policy development staff continually, ensuring that they build from a solid foundation in policy analysis and administration.
- Provide high-quality, well-organized information and resources that are quickly accessible.
- Practise a balance of timely and relevant service delivery with a continual eye to scanning the environment for new and emerging issues and problems.
- Policy development is at the nexus of political necessity and analytical research; therefore, policy analysts should keep a balance and be wary of sacrificing professional standards and rigour for political purposes.
- Confidentiality may be necessary; however, every attempt should be made to maintain transparency and open consultation from within and outside of

government and to make as much information as possible available for public review, discussion, and debate.

- Develop a good challenge function into the process of policy development – encourage a climate and environment challenge and debate so as to test limitations and unexpected design flaws. (Pal, 2001, p. 343)

Summary and recapping the argument

In summary, the role of the state in health care policy making and reform is a complex arena. What is known from the selected literature reviewed in this section is that there is a tension between individual liberty and a state's responsibility for delivering and funding health care. Contemporary Western industrial liberal democracies are tending to favour policy solutions that draw from market mechanisms to help governments deal with increasing costs to which they are reluctant to say no because of the unpopularity of doing so. During the 1990s, the debate swung toward considerable interest in market mechanisms that might help ameliorate the challenges of a sustainable health care delivery system. The research community, represented by a broad spectrum of academic institutions, agencies, and think tanks, undertook studies and conferences in response to the enthusiasm to explore these opportunities. In many cases, the intellectual elite became embroiled and became instruments of the syncretic process as constraining and competitive contradictions were worked out in discursive knowledge. The opinions range from the Friends of Medicare and Council of Canadians that sought to preserve the status quo, to the Fraser Institute that strongly articulated the introduction of market mechanisms into the public sphere, demonstrating that the intellectual elites were embedded and implicated in the politics of health reform. They all purported to have sound evidence to support their claims. Some added significant value to the debate by demonstrating greater transparency, extensive reliance on a broad spectrum of data, and reflexivity. The policy-making community is well aware of the tension between the use of sound scientific evidence, which is socially constructed to design and implement health care policy, versus doing what might be popular, expedient, or convenient. This section concluded with some advice as to measures that may be taken in an attempt to preserve the best possible chance of the public interest being protected in health care policy making during the interplay of evidence, values, ideology, and opinions.

Osborne (1998) and Scheurich (1994) provide us with an approach against which we can assess the truth value of a knowledge production activity in relation to a policy-making exercise. Analysis of the way that problems are derived, described, ascribed, structured, and talked about in the research and policy circles has a significant implication for what alternatives are identified and which solutions are implemented.

Conducting a deeper analysis and critically looking to the implications of policy actions on those who govern, as well as those who are governed, may help to explain the dominating ideologies, inflexible values, and uninformed opinions at play around a policy issue. This raises the issue of how to deal with the misuse of power of those representing "truth" to others. If those in political power subterfuge the various representations of truth or attack its emergent veracity in respect to improvement of individual or population health in the society at the cost of preserving their own or some other group's position of privilege or power, this is counter to the democratic emancipation of citizens to achieve their full potential. How does one address the dilemma for those who produce the knowledge that arises when "speaking truth to power?"

Three suggestions arise from the question. The first is to separate the policy-making and knowledge creation apparatus so that knowledge creation can take place without interference from the political dynamics circulating around an issue. The knowledge production activity must be linked and contextualized as well as relevant, but the intellectual elite must be permitted to arrive at an independent finding transparently, explicitly, and reflexively. The second suggestion is to have the respective communities conduct their affairs in compliance with the best practices in their field. A high standard of publicly accountable and transparent behaviour identified for each of the epistemic communities should be the expectation and requirement. The best practices should be revisited regularly to ensure that continuous improvement is taken into account as lessons are learned. The third suggestion is that the continuous improvement of best practices in policy making should be encouraged through a healthy challenge function that is at the core of a democratic society. Open arguments and debates of the issues bring forward the best knowledge from the quantitative and qualitative fields that exposit the ideas in the form of evidence about values, ideology, and opinions so that government can implement the best course in the interest of population health.

The next chapter provides a brief survey of the narrative literature that has emerged in Canada over the course of the development of the Canadian health care systems. The role that the emergent knowledge played in characterizing and informing the policy development process is noted.

SECTION THREE: COMPARATIVE CASE STUDY

Section 3 begins by contextualizing the health reform processes in Alberta and Saskatchewan within the broader Canadian setting. The narrative histories described in chapter 6 can be viewed from two levels: as articulated studies representing the perceived reality of the time, and as cultural artefacts exploring in a critical way the future path for health reform. The chapter concludes with identification and cataloguing of the various forms of narrative perspectives encountered in this literature review.

The thesis describes four themes extracted from the data collected from the interviews with the informants: politicians, policy makers, researchers, and citizen elites. The key questions related predominantly to the use of HQE in Alberta and Saskatchewan during health care reform policy making. Chapter 7 describes how the informants define HQE and how it is used. Chapter 8 explores the motivation behind the current movement to using HQE and identifies the barriers and confounding factors that inhibit its uptake. Chapter 9 examines the perspectives of informants on the sources of HQE and LQE and how and why they come into play during policy making. Chapter 10 explores how informants differentiate among and between values, opinions, ideology, and HQE and how conflicts among or between them may be resolved successfully or unsuccessfully. Chapter 10 concludes with some observations as to what the epistemic communities identified as opportunities for the future.

Chapter Six

Narratives: Perspectives on health reform in Canada with a focus on Alberta and Saskatchewan

Introduction

To understand the interaction of ideology, values, opinions, and high-quality scientific evidence to inform health reforms in the provinces of Alberta and Saskatchewan, it is necessary to understand the historical context from which the reforms originate. This selected literature review, otherwise known as narratives, will begin with an examination of the historical development of the Canadian health care system(s). The review will focus on the narratives that exposit the political/social and public policy perspectives of the development of the Canadian health care systems. The contribution and involvement of the Canadian research community will be surveyed. It must be understood that these socio-politico-historic studies are themselves the focus of phenomena in society and are co-opted into either challenging or protecting a constraining or competitive contradiction. The review examines the role of the state, particularly the role and responsibility for health care policy. The selected literature review concludes with an examination of the contemporary literature on the nature and role of research evidence, knowledge transfer, values, and ideology and their influence on health policy making.

Historical context

The "appropriate" role of the state in policy making, health care delivery, and funding to achieve health for its citizens is, as we have witnessed, contested terrain with dynamic social, political, and economic tensions and consequences. The commonly accepted role of the liberal state is to make the good life possible without specifying what a substantive good society is. The state exists for the well-being of its citizens – even if the citizens disagree on what constitutes their welfare. The jurisdictional responsibility for the health of Canadian citizens is provincial; however, political concerns (universal access and portability of services among provinces) has led the federal government to intervene through the federal spending power (Boychuk, 2002, p. 122) to enhance health care delivery and funding. My vantage point is 2005. The last two decades have witnessed a dramatic transformation of institutions and policies in health services delivery on the one hand and remarkable intransigence of power relationships (material culture) in the face of reform on the other. The changes and permanent elements of the health care system are rooted in the unique cultural and historical conditions and developments within the Canadian social and political landscape, as well as the influence of external global factors (Rice & Prince, 2000). Contemporary issues surrounding an appropriate role for the marketplace in alleviating perceived concerns for the future sustainability of the public funding of the health care system are symptomatic of the contested territory representing a particular component of the historical, social, and political forces attempting to mitigate a role for themselves in what frustrated policy makers and politicians are finding as elusive solutions to contemporary problems. It appears as though the market partisan forces and influences trump the evidence-based ideational influences in health care policy making because the state and the quality of evidence it uses cannot withstand the challenges from the marketplace. One way forward may be to buttress the quality and variety of the evidence brought to bear on the policy-making processes.

Five eras of historical development

A sentinel work by Meilicke and Storch (1980) provides us with a historical understanding and explanation of social welfare development in Canada. Writing at the end of the 1970s, and peering into the future, Meilicke and Storch were remarkably prescient in identifying the issues that would engulf public policy making in health care for the next two decades – the broad subject of this project.

> In little more than one hundred years since Confederation, the development of Canadian social security policy and programs has moved from an era of reactive and ad hoc problem solving to an era of extensive reassessment and reappraisal. During this time, the federal and provincial governments have come to dominate the planning, financing, and much of the management of the social security system. As the decade of the 1970s drew to a close, there was little doubt that a new era had begun. The era of reappraisal appears to have been a time of consolidation and assessment, which will now lead to a new era of revitalized action. (Meilicke & Storch, 1980, p. 13)

The Meilicke and Storch historical framework is based on a legal, political, and public policy orientation. Their historical description and analysis identifies the major studies conducted, dynamics resulting, legislation passed, and public policy forged in order to build the social welfare state. The authors developed a chronological nomenclature that divides the historical development of Canada's health system into five eras: (a) pre-Confederation, (b) Confederation to the mid-1940s, (c) mid-1940s to mid-1960s, (d) mid-1960s to mid-1970s, and (e) the future. This story provides the primary plot line for participants in health care reform and as such functions at a conceptual level in providing a unity for the Canadian identity in its evolutionary national narrative.

First era

Prior to Confederation in 1867, Canada was characterized by limited state involvement in the delivery of social and health care services. Social problems were deemed to be the natural concern of the family, local community, or church, rather than the state. Canadians were expected to pay for the services of doctors, hospitals, and other providers from their pockets. Those who were unable to pay had four options. They could (a) go without, (b) receive philanthropy (charity), (c) get social assistance from the municipality, or (d) obtain mutual aid (Crichton, Hsu, & Tsang, 1994, pp. 181-183). Growing urbanization and industrialization after Confederation led to a growing awareness on the part of underlying key agents who influenced the state of the need to organize action in response to the social security needs of Canadians who were being buffeted by unemployment, war, or misfortune.

Second era

The government responses during the second era are subdivided into three periods: 1867 to 1920, 1920 to 1940, and 1940 to 1945. From 1867 to 1920, municipal and provincial governments began with initiatives like welfare services in Ontario and hospital services in Saskatchewan. During the second period, 1920 to 1940, the Depression and First World War caused social dislocations, which caught the attention of the federal government. In 1927, the Old Age Pensions Act, Canada's first cost-shared federal-provincial program, was implemented, but not without an ad hoc approach because of the federal government's intentional encroachment into a provincial jurisdiction. Federal involvement in provincial matters evoked a crisis in 1937 when the Judicial Committee of the Privy Council ruled the federal Employment and Social Services Act ultra vires. A Royal Commission on Dominion-Provincial Relations (Rowell-Sirois Commission), charged with examining the areas of government jurisdiction in several fields, deemed that the provinces had primary responsibility for health and social services (Meilicke et al., 1980). During the third period, 1940 to 1945, the federal government developed several initiatives on a planned basis as a result of two studies undertaken in 1943: the Marsh Report on social security for Canada and the Heagerty Report on health insurance. The Marsh Report recommended a comprehensive national plan for social security and the Heagerty Report suggested extending health insurance to all Canadians. The division of powers between the federal and provincial governments meant that the recommendations of the reports would not come into effect for many years.

Third era

The third era (mid-1940s to mid-1960s) was characterized as a period of "disjointed incrementalism." Programs were implemented not on the basis of the rational plans developed in the previous era, but by virtue of opportunity and expediency at the time. The only exception was Saskatchewan, which led the way with health care planning and implementation (Meilicke et al., 1980). Saskatchewan established a provincial hospital services plan in 1947 – the first compulsory and comprehensive hospital insurance plan in North America. Provinces, in turn, introduced similar legislation and in 1958 the federal government passed the Federal Hospital Insurance and Diagnostic Services Act, with five provinces signing up and the remaining committing to a national program by 1961. Saskatchewan introduced the first medical insurance plan in 1962, followed by other provinces and culminating in 1968 with the passage of the Federal Medical Care Act. The Medical Care Act was the result of the federal Royal Commission on Health Services chaired by Emmett Hall (from Saskatchewan), who argued that "with almost the total population becoming entitled to prepaid hospital services, the next essential service to be organized is care provided by physicians and surgeons and some ancillary services all of which we refer to as 'medical services'" (Royal Commission on Health Services, 1964, p. 28). The funding formula was based on approximately 50% contribution from each of the federal and provincial governments to provide citizens with universal, comprehensive, portable, and publicly administered Medicare. Over the 20 years, the provinces developed their welfare infrastructure as a result of the bold initiatives of a few provinces. The programs grew to a national scope because of the incentives provided by the federal government to share in the costs but only after a critical mass of provinces had undertaken the lead. The achievements of this era created problems for the next era.

Fourth era

Meilicke and Storch (1980) characterize the fourth era, mid-1960s to mid-1970s, as being the era of extensive reappraisal. The reviews and inquiries were an attempt to examine the complex social security programs and recommend improvements in services, organization, financing, and cost control.

If by 1968 Canadians had universal access to a portable, publicly funded and administered health care delivery system, why were problems and issues continuing to emerge? One explanation is that although governments had come to an agreement on a national approach to a health care delivery system, several of the stakeholders, for example, physicians, were unhappy with the results – the perceived and real erosion of their autonomy. The 1970s and 1980s witnessed the commission of studies of the health care system. In spite of all the studies and recommendations during the 1970s and 1980s, no province other than Quebec undertook any significant reform of their health care system in an attempt to address the emerging problems and issues.

Studies of Canadian health care

John Browne (1975) prepared a summary of major studies of heath care for the Canadian College of Health Service Executives (CCHSE) in the mid-1970s. Using a matrix, Browne analyzed the studies and their findings or recommendations along four dimensions: (1) organizational issues, (2) fiscal policy, (3) quality, and (4) manpower. Each of the dimensions is tagged with the key improvements they are to make. For example, regionalization was recommended as a response to a belief that it would be more responsive to local needs and help coordinate services.

1. Organizational issues
    - Regionalization (improved responsiveness to local needs and improve coordination of services)
    - Decentralization (improved responsiveness to local needs and improved local coordination of services across types and levels of care)
    - Local health boards (improved sensitivity to local needs)
    - Consumerism in decision making (improved responsiveness to local needs)
    - Primary care organization (improved effectiveness and coordination of services)
    - Health promotion (improved effectiveness)

2. Fiscal policy
    - Control of cost increases (improved accountability and technical efficiency)
    - Allocation of funds to sectors (improved allocative efficiency)

3. Quality
    - Development and enforcement of standards (improved quality)
    - Evaluation of quality (improved understanding of outcomes from health care interventions)

4. Manpower
    - Education (improve credentials)
    - Rules (improve effectiveness of health care professionals)
    - Utilization (improve effectiveness and appropriateness) (Browne, 1975)

Browne (1975) identified and analyzed the Castonguay Report from Quebec (1970), the Manitoba White Paper (1972), Mustard Report from Ontario (1974), Foulkes Report from British Columbia (1973), Lalonde Report from the national perspective (1974), and the Hastings Report from the national perspective (1972). With the exception of the Castonguay Report, these reports and their recommendations were essentially shelved. The ideas and recommendations within the reports were too radical for the politicians and policy makers to challenge the emerging issues. In spite of the fact that the issues and problems identified in the reports were real, there was no strong incentive for the provinces to address them. Public policy tended toward maintenance of the status quo, with most problems being temporarily resolved by providing more funding to the delivery system without addressing the core issues. The fact that the problems and issues refused to go away as a result of their being ignored stimulated the federal and provincial governments to undertake yet another series of studies.

George Torrance (1998) provides a contrasting descriptive and interpretive account of the social development of the health care system in Canada against the backdrop of international developments using a loose convergence theory of development. This is exemplified by the view that most Western industrial societies have followed a similar trajectory of increasing the longevity and decreasing morbidity of their citizens in the evolution of heath systems. Torrance is somewhat less optimistic and patient than Meilicke and Storch (1980) in observing the building of the social welfare state. Torrance outlines the emergence of medical dominance and comments on its effect on the social development of the country, as well as identifying how Canada took its lead from Western European countries in introducing government health insurance. Torrance concludes by stating:

> However, in other ways, the main impact of the Canadian health insurance program was to institutionalize the status quo and hence increase the difficulty of structural changes needed to make health care more responsive to society. Despite their resistance to the programs, some of the main beneficiaries, at least initially, were the provider groups themselves. But the problems of conceiving health in a broader sense than crisis interventions in acute-illness episodes or of providing appropriate care to those for whom no cure is possible remained problems to be tackled. (Torrance, 1998, p. 19)

The manifestations of those problems are observed where contemporary emergent political, economic, and social circumstances have come to compromise the state's ability to improve (reform) the health system. Reform calls for changes to a system that is harnessed to a set of system-wide expectations, which are difficult to change. Torrance (1998) notes that his work is strongly influenced by the medical sociological work of Friedson (Friedson, 1970) and the structural-comparative-historical works of Anderson (Anderson, 1972) and Glazer (Glazer, 1970) on health systems, Rimlinger (Rimlinger, 1971) and Wilensky (Wilensky, 1975) on social welfare systems, and Moore (Moore, 1966) and Bendix (Bendix, 1956) on social transformation of modern societies.

Public policy and studying Canadian health care issues

Returning to a public policy perspective, Malcolm Taylor's (1978) book *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System* is the commonly accepted definitive work on the description and analysis of the development of Canadian public policy in health insurance. Taylor set himself to the task of describing and explaining the policy making, which led to the seven decisions made by the federal and provincial governments to introduce Medicare. He studied how, over a 30-year period, health insurance came into being in Canada. Taylor used Easton's (1965) systems analysis to structure his study to "identify and examine the impact of ideas, public opinion, interest groups, and political forces as they came to bear on the perceived problems, caused the decisions to be made, and shaped the design of the proposed solutions" (Taylor, 1978, pp. xiv - xv). Taylor worked with Easton's model that the political system in a society is "predominantly oriented toward the authoritative allocation of values in a society" (Easton, 1965, p. 50). Taylor illustrates through his analysis that the "history of health insurance in Canada is largely about conflicts in values held by the medical profession, the insurance industry, labour unions, farmers' associations, political parties and provincial governments, and about the decisions made by governments in their allocations of values that would be authoritative" (Taylor, 1978, pp. iv - v).

In 1991, the Canadian Hospital Association, Canadian Medical Association, and Canadian Nurses Association commissioned Douglas Angus to conduct a review of the significant health care commissions and task forces in Canada since 1983-84. The purpose of the review was to determine the implications of the studies for the acute care hospital sector. The institutional acute sector was concerned about the implications for them – just as Torrance had correctly predicted in his work – that their dominance of the health system was the cause of many of the emerging problems and issues. Angus (1991) identified the common themes, directions, and trends of the major commissions that were conducted in Newfoundland (three commissions between 1983 and 1987), New Brunswick (two commissions in 1989), Nova Scotia (one commission in 1989), Quebec (five commissions between 1983 and 1989), Ontario (six commissions between 1984 and

1989), Manitoba (one commission in 1988), Saskatchewan (one commission in 1988 to 1990), and Alberta (two commissions in 1987 to 1989) and by the national government (two commissions in 1983 and 1987). In the summary, Angus states, "The basis for these reforms is a concern to rebalance and redirect the system in three ways – toward greater emphasis on disease prevention and health promotion, toward community-based care alternatives and toward greater accountability" (Angus, 1991, p. 75).

Unlike the previous decade, which could be characterized as benign neglect (choosing to do nothing) on the part of governments, the 1990s began to see a number of provinces undertake a flurry of reform initiatives by regionalizing their health care services.[4] At a conference titled *Health Care – Innovation, Impact and Challenge* at Queens University in 1992, the stage was set for a review of provincial health system reform opened with the faculty statement, "Medicare is, yet again, in crisis. The good news is that there does seem to be a national consensus on something – the diagnosis seems relatively constant from province to province. The bad news is that the consensus appears to be that Medicare is in bad shape; certainly the rhetoric, if not necessarily the system, is fevered" (Deber, Baker, & Mhatre, 1992, p. 9). The scepticism bordering on cynicism contained in this sentiment was becoming quite common within academic circles, the research community, and the health delivery communities, as public policy seemed to be incapable of responding to the emergent and persistent challenges of (a) introducing primary health care, (b) developing integrated and coordinated health program delivery, (c) developing integrated and coordinated administrative systems, (d) containing costs, and (e) facilitating citizen participation. These studies highlighted the point that, although there was a desire on the part of governments to facilitate change in the health care system, the structures and processes appeared to be immutable.

At the same conference, Raymond Pineault (1992) delivered a paper on the reform of the Quebec health care system, which had the longest experience with health reform in the country. The title of Pineault's paper was "The Reform of the Quebec Health-Care System: Potential for Innovation?" The reference to the word *potential* and the use of the question mark was meant to elicit the feeling that the results were not yet in as to whether the reform initiatives in Quebec resulted in improvements to health care delivery. Pineault explains, "because the major elements of the reform do not necessarily refer to innovative concepts, but when looked at in the processes that led to their adoption, and in their relationship with contextual factors that I will discuss later they constitute innovation and they have certainly created a potential for innovation" (Pineault, 1992, p. 73). To analyze health care reform, Pineault developed a framework, which is reproduced in Figure 5.

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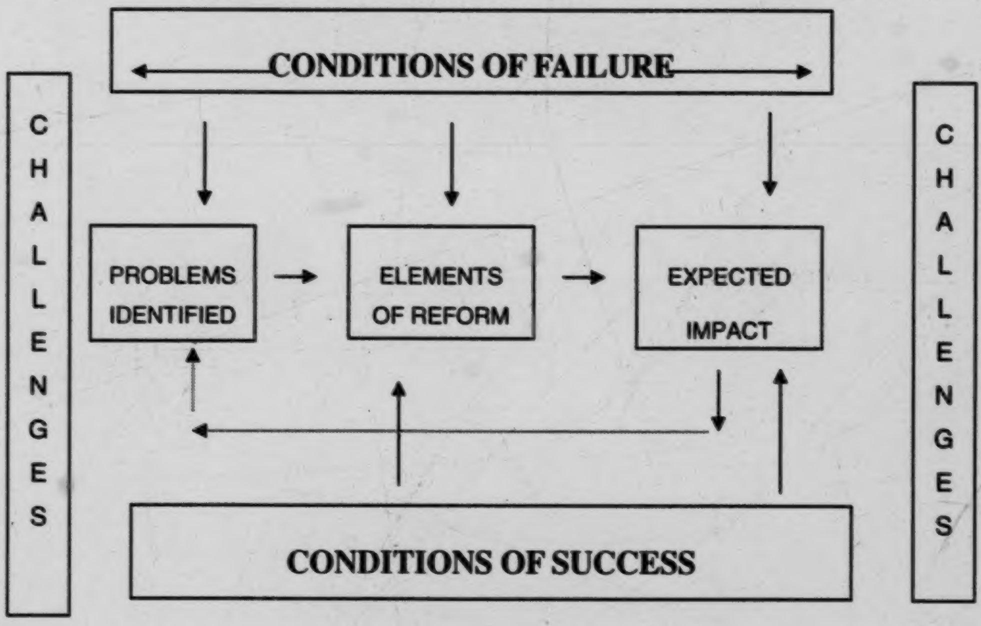
[4] There is often confusion between the terms *reform* and *regionalization* – they are not synonymous. I use the former to connote change with a notion of progress (goals of creating a better society) and the latter to refer to the decentralization of authority and responsibility to a local authority. Regionalization is a tool of reform to strengthen regional decision-making structures in order to reform the management and delivery of publicly funded health care services.

Figure 5: Pineault's framework for the analysis of the Quebec health care system.



In the model, the starting point is the problems identified for justifying a reform in a society. The solutions to the problems form the elements of reform. The elements of reform are put into practice and are expected to bring about changes identified as the expected impact. The problems should be solved (or not) and the degree of success is characterized by the feedback loop to the problem identified. The reform processes do not take place in isolation; rather, they occur within the societal context of internal conditions in the health system and external conditions from the environment (Pineault, 1992, p. 74). Unlike the other work published on health reform in Canada to that time, Pineault expanded the research and policy communities' interest to examine whether the health reform initiatives were solving the problems they were meant to address.

Contemporary studies and reviews of Canadian health care issues

The stimulus for health reform after years of neglect in the 1970s and 1980s picked up momentum during the 1990s. Health care being a provincial jurisdiction in Canada meant that each province was going down a different path of health reform with different destinations in mind and at different speeds. A patchwork quilt of inconsistency of health care delivery was beginning to emerge as to what services and treatments were available as publicly insured services in the different provinces. To keep health services executives across Canada informed as to the changes emerging in the provinces, the CCHSE began to publish a special report for its membership on health reform. The first report was published in July 1994 and within several months the contents became dated (Canadian College of Health Service Executives., 1994). The CCHSE chose to publish the report annually and the most current version is its 11th edition (Canadian College of Health Services Executives., 2004). The reports are not analytical, interpretive, or critical in their approach, but rather an inventory of the current state of health reform across Canada. The reports increased considerably in size and complexity as the respective health care systems diverged from a common standard of funding and delivery of services. Health Canada monitored developments across the country with a report of their own, which was first published in 1995 (Health Canada, 1995). The 1996 update reported on the level of progress along six common themes across Canada. This report was descriptive. It examined the (a) shifting system, (n) structural reforms, (c) fiscal initiatives, (d) health human resources, (e) determinants of health framework, and (f) accountability (Health Canada, 1996). Health Canada undertook the reviews because issues of a standard approach to universal access to different types and levels of health care began to emerge across Canada. This was monitored in order to determine whether provinces were contravening the Canada Health Act, which was built on the principles of universality, accessibility, comprehensiveness, portability, and public administration.

In 1998, Church and Barker published a paper that was one of the first to question the conventional wisdom of provincial governments charting a course of regionalization in an effort to reform their health care systems without a foundation of HQE. Ontario was the only province to not have regionalized its services. The authors state that the public policy instrument of regionalization was undertaken with the following expectation:

> The hope, of course, is that such action will allow provincial health care plans to realize the benefits of regionalization and thereby effect health care systems that are efficient, fair and responsive. But it is not clear that this will necessarily occur. Notwithstanding the alleged benefits of regionalization, some challenges face this particular approach to health care reform. A number of obstacles stand in the way of any attempt to integrate and coordinate health services. Achieving economies of scale for all services included within regional arrangements may be difficult. Regionalization arrangements also require a level of information for administrative purposes that may be difficult to achieve, and experience suggests that regionalization can fail to involve citizens in health care decision-making. Finally, regionalization may actually exacerbate – not ameliorate – the problem of high health care expenditures. (Church & Barker, 1998, p. 468)

The work of Church and Barker (1998) disturbed politicians and public policy makers who had put their stock into regionalization to deliver the provincial health care systems out of their crises. The reports of the 1970s and 1980s had emphasized the following themes as requiring attention:

- Contain costs.
- Increase the efficiency and effectiveness of health care.
- Enhance the responsiveness and accountability of health care delivery through decentralized decision making.
- Facilitate citizen participation.

To achieve these goals, Church and Barker (1998) identify seven challenges that face the successful regionalization efforts of decision makers: (a) integration of administration, (b) integration of the delivery of services, (c) coordination of the administration, (d) coordination of the delivery of services, (e) consolidation of funding, (f) development of an information infrastructure to facilitate the use of outcomes-based indicators, and (g) providing for citizen participation (Church et al., 1998, pp. 472-482). Church and Barker address each challenge in turn and provide evidence of characteristics of the health care system that make it difficult to improve the health system's efficiency, effectiveness, responsiveness to decision making, and delivery through regionalization. The authors conclude their article with the following warning:

> Despite the unbridled faith in regionalization, existing research provides few clues for policy-makers who must translate concepts into policies. Even more alarming is the lack of evidence concerning the impact of regionalization on the efficiency and effectiveness of health care delivery systems. What we have attempted to show in this article is that the introduction of regionalization schemes into the Canadian health care system will likely fall well short of expectations. Regionalization, of course, may work at the level of political symbolism, for it shows government responding to widespread concerns about health care in Canada. The fact that so many provincial governments have embraced regionalization certainly suggests that authorities see some political benefits in this line of action. But politically astute action is not the same as sound public policy. If governments in Canada wish to ensure a successful health care system, they must at a minimum rethink their commitment to regionalization. (Church et al., 1998, pp. 482 - 483)

Church and Barker (1998) brought to the fore the point that simply reorganizing the structural governance of the health care system would do little to effect the improvements that were necessary.

In spite of this warning, the Canadian health care system continued to be the object of further studies and commissions. The Canadian government sponsored the National Health Forum in 1994 to involve and inform Canadians and to advise the federal government on innovative ways to improve our health system and the health of Canadians (National Forum on Health., 1997). The results of the National Health Forum were never translated into policy action. In December 1999, the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to study the state of the Canadian health care system and to examine the evolving role of the federal government in this area. A series of five volumes were published between March 2001 and April 2002, responding to the terms of reference (Standing

Senate Committee on Social Affairs, Science and Technology., 2002). In April 2001, the Prime Minister established the Commission on the future of health care in Canada to be chaired by former Saskatchewan Premier Roy Romanow. The Commission was to make recommendations on sustaining a publicly funded health care system that balances investment in prevention and health maintenance with those directed to care and treatment. Canadians eagerly received the release of the Romanow Report in November 2002, with the anticipation of a resolution to the squabbling and impasse between the federal and provincial governments to act on health reform on a national scale. The report titled *Building on Values: The Future of Health Care in Canada* (Commission on the future of health care in Canada, 2002) harkened back to an observation made in Taylor's (1978) work that the history of health insurance in Canada was about the conflicts of values. Romanow did not restrict the Commission to studying values. In his message to Canadians introducing the report he states:

> My mandate was to review medicare, engage Canadians in a national dialogue on its future, and make recommendations to enhance the system's quality and sustainability. At the time, I promised Canadians that any recommendations I might eventually propose to strengthen this cherished program would be evidence-based and values-driven. I have kept my word (Commission on the future of health care in Canada, 2002, p. xv).

The importance of using good evidence to inform health care policy making had arisen during the National Health Forum, but Romanow for the first time asserted the importance of using scientifically derived evidence and values in building Canada's health care system. Romanow unequivocally underlined the importance of ensuring that the future of health care is built on the values of Canadians and sound scientific evidence, what is referred to in this thesis as HQE.

Studies continued to be conducted in the provinces with the Commission on Medicare, known as the Fyke Report, being released in April 2001 in Saskatchewan. In Alberta, former federal Finance Minister Don Mazankowski chaired a committee that investigated the future sustainability of Alberta's health care system. The report was released in December 2001 to the Premier's Advisory Council on Health for Albertans. The

Commission of the Study on Health and Social Services in Quebec (Clair Report) was concluded in 2000. In New Brunswick, the Sivret/Newbould Report was submitted to the Premier in early 2002. Ontario was the only province that did not undertake the regionalization of its health system; instead, it acted on the recommendations of the Health Services Restructuring Commission, appointed in 1996 for a 4-year term to guide hospital restructuring and advise the Minister of Health on other health reforms.

In Alberta and Saskatchewan, the recommendations of the Mazankowski and Fyke reports are illustrated and compared in Table 15. The contrast of approaches in the two provinces becomes pronounced as one notes Alberta's approach as encouraging individual responsibility for their health, curtailing medically "unnecessary services," and encouraging innovation, choice, and a diversified revenue stream. Saskatchewan, on the other hand, looks toward an integrated primary health care approach, rational planning, a quality-driven health care system, and future investments in the health care system.

Table 15: Mazankowski and Fyke Reports: Summary of Recommendations

MAZANKOWSKI REPORT	FYKE REPORT
Staying Healthy - this recommendation is a commitment toward keeping Alberta's public healthy. Specific reforms include increased support of children in poverty, providing better public health awareness, reduce tobacco use, and provide incentives for people to stay healthy.	Development of an integrated system for the delivery of primary health services by: •Establishing Primary Health Service Teams bringing together a range of health care providers including family physicians • Integrating individual teams into a Primary Health Network, managed and funded by health districts, which includes enhanced community and emergency services • Converting many small existing hospitals into Primary Health Centres designed to support Primary Health Teams • Ensuring that comprehensive services are available 24 hours a day, 7 days a week, including a telephone advice service
Putting "Customers" first - this recommendation involves understanding patients as "customers." Reforms include providing a 90-day guarantee of access to selected health services and providing more choice in the health care services they receive and where they receive them.	

MAZANKOWSKI REPORT	FYKE REPORT
Reducing Services Covered by the Public Health System - this recommendation calls for a reduction in the services a person would receive through their public health insurance plans. An expert panel would be established to review services currently insured and whether coverage should continue. Once a service was "de-listed," coverage would have to be through the private sector.	Development of a province-wide plan for the location and delivery of specialized services that include: • Tertiary services delivered in Saskatoon, Regina, and Prince Albert • A network of 10 to 14 Regional Hospitals to provide basic acute care and emergency services • Districts contracting with specialists • Utilization of beds and resources based on standards established by a Quality Council
Invest in New Technology – this recommendation focuses upon the importance of new technology (in particular information technology) in making the health system more efficient and cost-effective. Reforms include the development and implementation of an electronic health record and a debit-style electronic health card to track and improve outcomes in health.	
Encourage Choice, Competition, and Accountability in the Health System – this recommendation would impose greater choice, competition, and accountability in the health system. Specific reforms include making regional health authorities more accountable and specialized, as well as blending private health care with public systems.	The continuation and/or the development of: • Public health, health promotion, and disease and injury prevention strategies • Regular reports on defined and measurable health goals • Strategies to address the broader determinants of health • A Northern Health Strategy
Diversify the Revenue Sources – this recommendation retains governments as the primary contributors to health; however, with the addition of alternative sources of revenue. Reforms include increasing health care premiums and allowing regional health authorities to raise additional revenues.	Continuing development of performance indicators: • The establishment of a Quality Council • Annual reports on the health system • Incentives and funding to develop accountability and quality
Attracting, Retaining, and Making the Best Use of Health Providers Reforms - includes developing a "workforce plan" that defines the roles of various health providers and anticipates future demands on postsecondary education, improving morale, and introducing new approaches for paying physicians.	Introduce 9 to 11 health districts, and clarification of their relationship to the Government of Saskatchewan: • A structured dialogue on the delivery of health services to Aboriginal people • Coordinated human resources planning and management on a provincial basis • The renewal of health science education

MAZANKOWSKI REPORT	FYKE REPORT
Make Quality the Top Priority for Alberta's Health System - reforms include the establishment of an "Outcomes Commission," which would measure outcomes, track progress, and report results.	programs, including increased funding for health research, equalling 1% of public health spending • Investments in information systems including the development of an Electronic Health Record
Promote Alberta's Health Sector as an Asset to the Province - this recommendation is to enhance the economic benefits and spinoffs of the health care industry. Reforms include the development of provincial centres of excellence in health research and the commercialization of new products and services developed through medical research.	Future investments be directed to: • Changing the organization and delivery of primary and specialized services • Enhancing the overall health of the population • Research to support health services education, and to develop and report on performance measures, service quality, and value for money • Managing change and creating a quality-oriented health services culture
Establish a Clear Transition Plan – the final recommendation is administrative. Specifically, it calls for continued studies into the implementation of the reforms, informing the public when changes occur, and addressing barriers to implementation (i.e., legislation and union agreements).	

The difference in the emphasis of the two reports is striking. The Mazankowski Report clearly identified the need to reduce the coverage of nonessential public health services in the public health system, the introduction of a diversified revenue stream for health care, and choices for access to services. This approach is clearly characterized as looking to the marketplace for solutions. The Fyke Report, on the other hand, emphasized integrating system-wide planning and delivery, the development of performance indicators, and investing in health promotion and primary care. Fyke sees the role of state as paramount in achieving future success in health care delivery, while Mazankowski turns to the marketplace.

What are we to make of these reports and their impact on policy making in health care in Canada? Leslie Pal (2001), in the opening chapter of his book on policy analysis, remarks:

> Public policies are an essential element in modern democracies in that they provide guidance for government officials and accountability links to

> citizens. Governments may do things for a wide variety of reasons – patronage, political competition, reflex, tradition – but when their actions are grounded in policy, they presumably are taking a course of action that has been thought through in terms of the nature of the problem they are addressing and the circumstances that they face. (Pal, 2001, p. 1)

The literature reviewed in this chapter highlights the attempt by the respective governments to explain the nature of the problems and how the governments might effectively respond to them through public policy. The fact that the reports are as repetitive as they are is a sign that the solutions are difficult to implement because of the desire of stakeholders and the constraints of the understandings embedded in the cultural artefacts to maintain the status quo, for example, the ideological traditions in each province. During the period 1987-2003, a number of health care policy reform initiatives were undertaken in Alberta and Saskatchewan. Table 16 illustrates the primary initiatives in the two provinces.

Table 16: Health Reform Initiatives in Alberta and Saskatchewan 1987 – 2003

ALBERTA	SASKATCHEWAN
Regionalize the health care system Encourage citizen participation Move to population-based funding Emphasize wellness Introduce the electronic health record	Introduce the wellness model Regionalize the health care system Encourage citizen participation Close or convert 52 rural hospitals to health care centres

Three of the initiatives (shaded) were identical in the two provinces. Where they differ is that Alberta emphasized a move toward population-based funding and introduction of the electronic health record, while Saskatchewan faced the closure of 52 rural hospitals because of a dwindling provincial treasury.

Policy change to benefit broader population health when it compromises or takes away certain interests mobilizes resistance on the part of those interests toward that policy change. In Alberta, Friends of Medicare mobilized in response to the government approach to introducing marketplace solutions to reform the health system. In Saskatchewan, the rural community mounted an opposition to the closure of the rural hospitals. The policy actions initiated in the two provinces are contrasted by the different ideologies that inform the government, the NDP in Saskatchewan and the Progressive Conservatives in Alberta. To get at the self-understanding of actors in this policy process, I need to specify a definition of policy amidst a proliferation of definitions. There are several definitions of public policy, ranging from Thomas Dye's (1984) "whatever governments chose to do or not to do" (Dye, 1984, p. 1) or Lerner and Lasswell's (1951) "the most important choices" (Lerner & Lasswell, 1951, p. 5). In this project, I adopt Pal's (2001) definition of public policy: "a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems" (Pal, 2001, p. 2). I chose this definition because of the inclusiveness and recognition of the multifactorial characterization of the source of problems and the fact that it is action oriented (or not) by agents of the state and because of its consistency with my epistemological and methodical assumptions that inform this critical pragmatic project.

Discussion as a context for the research

The primary data for this study were collected from July to October 2003 and the recall of the informants covered the period 1987 to 2003. The background narrative and related studies covered in this chapter provide the key elements in which the participants told their own stories, elaborated on their own understanding, and showed the important role that researchers play in providing a context of meaning assimilated by the informants.

The selected literature surveyed in chapter 6 provides high-level exposure to the variety of narrative histories that have been written about the health care system, its development, and its challenges. On closer examination, the narrative reviews can be categorized into five groups. These groupings are not mutually exclusive or exhaustive; researchers may move from one group to another and there may be others that I have not captured in this review. The first group I characterize as the intellectual group and they are interested in policy analysis and social political phenomena. Their interest is in the substance and methodologies associated with policy making. Their writing may arise as proceedings of conferences that have taken place on the subject of health care reform or policy making. Examples of intellectual literature are Taylor (1978), Meilicke and Storch

(1980), and Pineault (1992). The audience is primarily the academic and policy analyst community.

Group 2 consists of the critical analyzers who write for the purpose of problematizing the subject of health care by questioning conventional wisdom and the power relations inherent in maintaining the status quo. They ask whether there is not a better way. Examples of critical analyzers are Torrance (1998) and Church and Barker (1998). The audience is made up of the academics and policy analyst community.

The third group I call the inventory-of-problems group. The inventory-of-problems literature is generally the focus of a task force, commission, or other government-appointed body to review and respond to problems. These always contain a set of recommendations on how to respond to the weaknesses inherent in the health care system. Recommendations tend to reflect the political currency of the day. Examples of these are the reports authored by Romanow (2002), Fyke (2001), and Mazankowski (2001). The audience is primarily policy makers, politicians and citizens.

Group 4 are the stock-taking group. They attempt to itemize the developments in the provinces across Canada and provide as current information as possible on the state of health care reform in each of the jurisdictions. Browne (1975) and CCHSE (2004) are examples of the stock-taking group. The audience consists of policy makers, administrators, policy analysts, and researchers in the health care system.

A fifth group whose literature is not captured in the narrative review are the members of think tanks. This literature is covered in chapter 5 because of its relevance for the emergence of new ideas from the marketplace, which have come to impinge on the policy-making landscape. The audience for this literature is primarily policy makers, patrons, and subscribers of the think tanks and the public. Examples of key members of think tanks are McArthur et al. (1996) of the Fraser Institute and Jerome-Forget and Forget (1998) of the IRPP.

Focusing on the two most recent reports that have impacted health reform in Saskatchewan and Alberta (the Fyke and Mazankowski reports), one finds some similarities such as regionalizing the health systems, introducing a wellness model, and encouraging citizen participation. There is a significant difference in health policy approach in the two reports. Mazankowski looks to dealing with what are nonessential public health services, introduction of a diversified revenue stream, and moving toward population-based funding. The marketplace is looked to for help in dealing with issues in health care. The Fyke report, on the other hand, identifies the state as clearly responsible for the conversion of rural hospitals into health centres and, at the same time, identifying mechanisms to increase the access and quality of health care.

Summary

Narrative histories around health policy making appear to fall into five groups: (a) intellectuals, (b) critical analyzers, (c) inventorizers of problems, (d) stock-takers, and (e) think tankers (Table 17). They all have different purposes, audiences, and credibility and cannot be accepted at face value as equally meritorious in representing the past accurately; they have an axe to grind or promote the public interest. There is an element of self-interest in each and each provides rich cultural resources to inform the construction of the "myth" story about where public health care came from and where it might be going. Whether this objective culture enables or constrains reform is related to the historical dynamic and the way that sociocultural agendas use these stories to further their self-understandings of best evidence, policy, and practice.

Table 17: Narrative Histories and Characteristics

	INTELLECTUALS	CRITICAL ANALYZERS	INVENTORIZERS	STOCK - TAKERS	THINK TANKERS
Objective	Knowledge	Health reform	Agenda setting	Accurate data	Advance interest
Audience	Intellectuals	Intellectuals reformers	Policy makers	Administrators	Society patrons
Bias	Neutral	Toward reform	Toward action and public accountability	Neutral	Toward interest
Empirical orientation	Objective	Theoretical	Investigative	Detailed and conscientious	Opportunistic
Values	Neutral	Reformist	Smooth transitioning	Neutral	Narrow
Adjudicated	Peers	Peer reformers	Electorate	Users	Allies
Perspective	Societal	Marginalized	Societal	Comprehensive	Patron interest
Policy position	Neutral	Reformist radical	Pragmatic	Neutral	Reformist
Funding source	University or research grants	University or research grants	Government	NGOs	Patrons
Motivation	Discovery	Mission	Government	Reputation	Interests
Stance	Broad	Postpositivist	Pragmatist	Positivist	Varied

In summary, it is clear that who, or what entity, is undertaking the writing of the narrative history, its purpose, and the intended audience dictates how history will be received and used. The intellectual group attempts to be as objective and open to exploring new ideas about health reform as possible. The critical analyzers question the power relations that maintain the system in its current state and identify underlying barriers to prevent "real" reforms from taking place. The inventory of reformers perform a duty on behalf of the state, reviewing the problems by their definition and making a series of recommendations for government to consider in remediation. The stock-taking group attempts to keep a current and accurate understanding of the changes taking place in the health system. The think tankers challenge the status quo, but rather than focusing on power structures like the critical analyzers, they focus on opportunities for their patrons' interests, which are often in the marketplace. The picture that emerges in respect to characterizing the narrative history producers is that, while they each play a role in informing health policy decisions, they each have different goals, incentives, and purposes. Policy makers must make sense of all forms of knowledge that are created and disseminated around health care policy.

This thesis is situated with the self-understanding that these dynamics occur in society and may influence a study of this nature. By using a GT approach, I capture the thoughts and actions of informants in the next 4 chapters. These will be collated and synthesized to inform the four epistemic communities' perspectives on the use of evidence and values to inform policy making.

Chapter Seven

What is HQE and how is it used?

Introduction

This chapter will describe and analyze the responses from the four epistemic communities – politicians, policy makers, researchers, and citizen elites – on questions and issues surrounding what they define as HQE and how effectively they think it is used. The purpose is to unpack what each of the epistemic communities perceives to be good evidence versus poor evidence for policy making. This is an important question to interrogate because of what will count as the evidence to inform policy making. The literature reviewed indicates that although there is no guarantee that good-quality evidence will lead to good policy making, it does improve the chances of it occurring. In this project, quality evidence is defined as empirically derived knowledge or information through a consistent and reproducible approach, which is internally consistent, valid, and verifiable, with the power of generalizability and relevance to the local setting. LQE, on the other hand, is generally poorly constructed without a verifiable empirical basis and without relevance to a local setting. Explicating the perspectives of the actors on what they perceive as the characteristics of the evidence and where it can be shown to be deficient and weak will help inform the development of a theory or model that encourages the creation and critical appraisal of the evidence to assess its veracity for application in policy making. Deficiencies in the evidence production, application, appraisal, and policy implementation processes will be highlighted in an effort to arrive at improved mechanisms.

The chapter concludes with the characteristics of HQE, as well as by highlighting the similarities and differences in the views of the four epistemic communities in Alberta and Saskatchewan. Identifying the differences in the perspectives provides the opportunity for developing ways to bridge between the epistemic communities, with a view to encouraging the creation and use of HQE in policy making. Several overarching concepts will be derived that will set the stage for further discussion, analysis, and model building in chapter 11.

What is HQE and how is it used?

Asking the informants how they defined HQE was an attempt to gain an appreciation of what the different informants perceived to be HQE, and if and how this varied among them. The objective was to gain an understanding as to whether there were qualitative differences between actors regarding their perceptions of LQE and HQE. Examples of the instrumental use of HQE to inform policy making were also sought.

Politician

What is HQE?

Politicians in Alberta and Saskatchewan identified several facets of HQE in common. They felt that reputable organizations like the AHFMR, Health Services Utilization Review Commission (HSURC), Canadian Medical Association, or a well-credentialed individual, like the Dean of a Medical School, were sources of HQE. An Alberta politician stated:

> *...one of the most important legacies of the Conservative government spanning over the last 30 years has been the work done through the Alberta Heritage Medical Research Fund. It has provided a very high level of gold standard research in health sciences that have application to health care that has benefited Albertans.*

Politicians in both provinces emphasized the view that HQE needed to take into account the public dimension to the question being considered; in other words, was the HQE evidence "sellable" to the public? An Alberta politician noted:

> *Health care, most of us that have been involved in it very long ... we all know what needs to be done. It's a question of the political will, how you do it, and get the public and the people in the system onboard.*

Politicians in Alberta and Saskatchewan relied on the staff in government to provide advice on the strength and quality of the evidence being considered, as well as being purveyors of HQE themselves. There was, however, a tension noted by one Saskatchewan politician between policy makers and the politicians during the move toward health reform. He noted:

> *...compounding the difficulty was the sense that I had that the department officials were very reluctant to move into this radically new path. They were so used to the traditional forms of governance, the standards and the measurements of whether those standards had been met, that there was either explicit or implicit reluctance to provide high quality evidence and data and information. It sounds a bit damning but I don't mean it that way. I just think it is the normal and natural way, which it operates.*

Politicians from Saskatchewan were more likely than those from Alberta to characterize the complexity associated with differentiating HQE from LQE by referring to it needing to be independent, empirically based, and peer reviewed. Evidence that was delivered by a vested self-interest needed to be interrogated with a view to exposing the interest. A former Minister of Health responded by saying:

> *...it should be objective in the sense that it isn't from a... vested interest. It should be from someone who is educated in some way ... competent to be presenting evidence. It should be empirically based... That's how I would define high quality evidence.*

Politicians in Saskatchewan also expressed the view that during their time in the Opposition, in the legislature, they benefited a great deal by having witnessed the briefs and submissions, often comprising HQE, that were made to the Commission on Saskatchewan's future directions in health care (Government of Saskatchewan, 1990). Hearing first hand about the problems and issues inherent in the health care system, this information was used by the NDP to structure their own vision and strategic plan for health reform in the 1990s after they formed the government. Saskatchewan politicians felt that an independent validating process to assess the veracity of research evidence should be established. They felt that organizations like the CIHI, the HSURC, or the newly formed Saskatchewan Health Quality Council would be appropriate organizations for assessing the validity of health evidence. Saskatchewan politicians identified one other mechanism for bringing HQE forward, suggesting that a public forum could be organized by inviting leading international experts to participate, speak, and debate the evidence. Finally, the observation was made that HQE was important to produce and where there were identified gaps in knowledge, even though it was costly and time consuming, HQE was necessary.

How is HQE used?

In respect to how politicians rated the uptake of HQE to inform policy making, most responded with the comment that it depended on the policy question. One politician in Alberta identified an example of where there was ineffective uptake and one example where it was a somewhat effective uptake. A second politician stated:

> *...it has played an important role in health policy, but not nearly to the extent that it ought to... there is not a strong connection that allows such research to have the life of public policy breathed into it. Research... initiated at the request of government ...does find expression in public policy. But research that is done at the initiative of, for example, health sciences, faculties, often does not see the light of day in government policy-making venues.*

Other Alberta politicians avoided making the rating assessment and emphasized the importance of other factors besides HQE that should dictate health care policy making. From their perspective, evidence is necessary, but it is not sufficient on its own. Public acceptance of the policy direction was also identified as an important factor.

Saskatchewan politicians' responses ranged from very effective to somewhat effective for the uptake of HQE. The politician who characterized the uptake as very effective stated that some form of evidence was always used – it may not be HQE, but it was the best available at the time. The politician who perceived the uptake as somewhat effective felt that, since the Department of Health had become reorganized to reflect the regionalized structure of health care in the province, they were expediting and using data and evidence more effectively. The politician who identified the uptake as effective likened health care delivery in the province to a large ship that takes time and a great distance to change the course and speed of travel. Leadership by the Minister and

Deputy Minister setting a high expectation for using HQE was also identified as an important factor. In respect to the rate of uptake of evidence, one politician pointed out that the closure or conversion of 52 hospitals in Saskatchewan was a very unpopular policy move. For it to be successful, it had to be undertaken very early in the government's term and implemented as quickly as possible so that the remainder of the term could be spent settling things down. In his words:

> *There are four years between elections, essentially. You really only have one year to make major changes. The second year you implement them, and then the next two years you try and make everybody like them because you're heading back to the elections ... your time frame ... some people think you've got four years from one mandate to the next ... you don't have.*

The instrumentality of HQE

The politicians of the two provinces agreed that HQE was important, but they differed in their view of how instrumental HQE was in informing health care policy making. An Alberta politician identified the Expert Drug Committee, whose role it is to list and delist pharmaceuticals on the provincial drug formulary, as an example where HQE was used to inform questions of policy. As noted earlier, the politician also felt that there was high-quality research conducted at the two major universities in Alberta, research that often does not see the light of day. Research, however commissioned by the department, would often be used to inform policy questions. His feeling was that there was a significant gap between the work of researchers and its application to policy, for example:

> *... some of them are locked into a University environment that says ... if you do all of this research something good will happen. But, most researchers don't understand the nature of politics – that's the problem.*

Another politician identified that some research was simply not timely and that public acceptance of it was lacking. A Saskatchewan politician pointed out that when the NDP came into office, they undertook an ambitious 8-month project to review the evidence to inform their vision and strategic plan for health reform in the province. A former Saskatchewan politician stated:

> *...my point being that I think the impetus, whether it is trying to promote the wellness model or trying to decide how to allocate the resources, was very much based on data and studies in terms of what things were most effective, vis-à-vis population health and, also, what was going on in some of these institutions.*

One politician observed that the question of how instrumental evidence was is relative because the Thompson Commission in Saskatchewan had identified benefits organized around the wellness model of health pre-1960 and it only started being implemented in the 1990s, suggesting that it takes time for good ideas to find their way into policy.

Summary

Politicians, whether they were from Alberta or Saskatchewan, thought of the reputation of the organization or the individual as being a primary consideration in assessing what HQE is. They also relied on their staff in the government department to provide HQE and to assess it. A politician in Saskatchewan did note that when his government came into office there was some resistance on the part of departmental staff to provide information that was oriented toward a new policy direction. Politicians from Saskatchewan were more likely to characterize a distinction between poor evidence and good evidence with criteria such as its independence or objectivity, validity, and whether it was peer reviewed. Politicians in both provinces felt that evidence prepared by a vested interest should be disaggregated to expose bias if there was any. Reputable organizations like HSURC (now replaced by the Health Quality Council), AHFMR, or CIHI could serve as validating entities in assessing the quality of the evidence. Politicians from both provinces felt that the HQE had to take into account public sentiment. Saskatchewan politicians identified public forums as useful mechanisms to stimulate public debate and advance public knowledge. Underlying this point is the fact that politicians have a difficult time introducing policy that is not in some sense grounded in the direction that the citizens are wishing to move. It means that citizens must be well informed of what the evidence says.

In respect to the uptake of HQE, most politicians responded that it depended on the issue. They all implored the need for other considerations, besides HQE, to be taken into account in making policy – evidence is necessary, but alone, it is not sufficient. This raises the point that other evidence in the form of qualitative research may well play an important role in informing the policy question. The rate of uptake of evidence appears to be closely linked to whether it deals with a narrow issue versus a broad issue, the timing (both in terms of election cycle and public readiness), the bureaucratic structure reflecting the directions of reform, and whether there is public acceptance or understanding of the evidence. Politicians identified a gap between the policy-making apparatus in government and the research findings of university researchers working independently; commissioned research appeared to be more useful more often. These observations confirm what was identified in the literature review but they also underscore the fact that politicians wish to have good-quality evidence provided to them. However, it does not appear as if adequate mechanisms currently exist to have the research community provide it at the policy table in a relevant and timely fashion.

Policy maker

What is HQE?

The views of policy makers in Alberta and Saskatchewan as to what constitutes HQE were consistent in a number of ways. They stipulated that the evidence should originate with a reputable and independent source, be validated, peer reviewed, timely, consistent with relevant data, and relevant to the local context. This is often referred to as the generalizability of the evidence. The challenge in the generalizability of evidence is recounted by a Saskatchewan policy maker who stated:

> *...a researcher once said to me, "It's the 'we are not Sweden' problem." You know, because you can just say Swedish model works well but you have to say so, but Canada is a different country, a different regional variation. It's a very different place with a different history so how does that research really translate in a Canadian context?*

All policy makers underlined the importance of contextualization of the evidence. In addition, the evidence should have some broad base of support. Saskatchewan policy makers pointed out that the HQE should have its bias or perspectives clearly stated. They also felt that HQE needed to take the different perspectives that might bear on the evidence into account and explain them. Alberta policy makers felt that the evidence should come with a convincing presentation pitched to an appropriate level, be it politicians, policy makers, researchers, or citizens.

A Saskatchewan policy maker with experience in Alberta and Saskatchewan made the observation that HQE is more likely to be sought and used to support policy making in Saskatchewan than in Alberta:

> *In Saskatchewan I think it had probably three or four times more influence than it does in Alberta. And I think two reasons. One is out of economic necessity. When you don't have money to throw around, you have to provide evidence to the stakeholders to demonstrate that what you're doing makes sense...a lot of times they don't like what you do but they can understand why you did it... you know, it was based on some evidence or logic as opposed to lobbying or ideology or whatever the case may be.*

A policy maker referred to the question raised by the Alberta government about whether there was evidence to support the private delivery of health care in the province. This caused some consternation among the policy makers and politicians, as the request for the information did not materialize in any substantial HQE. It was surmised by a policy maker that this led to the transfer of senior staff from Alberta Health and Wellness.

How is HQE used?

All three policy makers in Alberta assessed the rate of uptake of evidence to be somewhat effective, whereas in Saskatchewan, one rated it as very effective and two as effective. The Alberta policy makers gave the following reasons for their assessment: there is a lack of research (primary research) to inform the broad macro questions of policy; the research available does not adequately address the issues of context and values; and the cost cutting of the early nineties reduced the staff in the government health department, thereby decreasing their policy-making capacity. In spite of these issues, it was felt that with micro issues, which require technical evidence, there has been effective uptake (e.g., introduction of new pharmaceuticals on the provincial formulary). One policy maker pointed out that the Rainbow Report (Premier's Commission on Future Health Care for Albertans., 1989) recommended that 1% of the health care budget be set aside for health research – this recommendation was not adopted during the years of cost containment. During the 2002-03 fiscal year, Alberta Health and Wellness expended $6.8 billion on health care in Alberta. One percent of that figure for health systems research would be $68 million per annum. Regardless of what one defines as health systems research, a figure far less than the goal set by the Rainbow Report was actually spent in that fiscal year.

Saskatchewan policy makers had a much more positive orientation toward the ability of government to develop policy based on HQE. One policy maker commented that the translation of HQE into policy was relatively easy but what was challenging was the communication of it to stakeholders and the general public. What often exacerbated this were the media and press fanning the flames of controversy. A particularly difficult issue in Saskatchewan was the closure and conversion of 52 hospitals, which affected the communities' economic viability. However, the commitment of the Minister and Deputy Minister of the day to act on HQE with open and transparent data helped them weather that storm. A Saskatchewan policy maker offered a comparison in the way the tough decisions around health reform were implemented in the two provinces:

> *When Saskatchewan started their reform... they started in the fall of '93 when they closed 52 hospitals. And unlike Alberta, there it was the department staff, ministers and MLAs that went out and closed the hospitals... But the trauma was experienced by ministers, MLAs and the senior public servants. And many people think that's a more appropriate way because literally ministers and MLAs were accountable for the decisions... in Alberta there was sort of this buffer between the elected people and the electorate.*

The instrumentality of HQE

Policy makers generally differed in their perspectives on how instrumental evidence was to inform health care policy. Two Alberta policy makers stated that it depends on what is meant by instrumental. Instrumental defined by a researcher may mean wholesale adoption of their findings, whereas they may not appreciate the complexity and competing goals inherent within government, which makes it very difficult to implement policy. The policy maker commented:

> *...I think one thing researchers sometimes lack is an understanding of just how complex decision making is in the government. You know, there are many goals in government. They tend to be very broad, value-based kinds of goals and are quite often conflicting. They're not well defined and governments have to make trade offs between these goals... So I'd say it's relatively instrumental. That doesn't mean there's a direct line between the evidence that we looked at and the ultimate policy decision but it's an important consideration.*

A third policy maker pointed out that at the technical level, research findings (areas of efficacy and efficiency of health services) are often much easier to implement than they are at the broader economic or fiscal contexts, where other values and considerations may outweigh the benefits of adopting the evidence. Policy makers have also been successful in using evidence with more focused questions rather than broad macro questions. One Saskatchewan policy maker stated:

> *I think the challenge... for decision makers is that the individual research studies risk being over-interpreted in the policy environment because we tend to need to generalize and they are often very narrow... That's where policy synthesis is very helpful. So that's probably what I would say is the highest quality evidence. Also very useful if there's actually been some implementation... the greater the understanding of what actually happens when you implement it and what are the success features or the critical factors.*

Saskatchewan policy makers appear to be more optimistic about the role of HQE in informing health care policy making, although it was recognized by one policy maker that sometimes small *p* and big *P* politics or the quick passage of time could very easily overtake HQE. In policy circles, this phenomenon is one where the urgent displaces the important at the policy table. A policy maker from Saskatchewan recounted the difficulty of separating ideology from HQE on the issue of regionalization:

> *...at times we were a bit, I'll call it 'ideological' about it. So for example, the decision that was made at that time to go to elected or partially elected boards without a tax base, I think there was lots of literature that said questionable proposition to have elections but no financial, independent financial stream of support...And it was difficult in the department sometimes to question because there was a sense of "we are just – we have a vision" and the word 'vision' was used a lot but you know, the wellness vision. So, strong evidence base but then it became hard to*

> *question some of the caveats about the degree to which we were decentralizing.*

One of the challenges identified by one of the policy makers was that Saskatchewan was at the leading edge of reform in Canada and so there was not very much evidence to go on. Policy makers in Saskatchewan did identify three areas where they felt that HQE was instrumental in policy making: identifying the 52 hospitals to be closed in Saskatchewan, the creation of the HSURC to provide independent and HQE to inform policy making, and the change in focus and approach of the Department of Health from being institutionally focused to being wellness focused. A policy maker with experience in Alberta and Saskatchewan felt that, between the two provinces, Saskatchewan had a greater chance of using HQE to inform policy than Alberta did. Policy makers were emphatic that the breadth and type of evidence that needed to be brought to the policy table needed to be expanded to include other factors such as values and public opinion.

Summary

Policy makers iterated many of the same characteristics that politicians did about what constituted HQE: it needs to be timely, validated, consistent with relevant data, and generalizable and it should have some broad base of support. HQE should also take into account different perspectives and these should be clearly communicated at an appropriate level to its various audiences. Policy makers expressed some concern about the "cherry picking" of evidence to support a particular point of view or position. Most policy makers felt that the uptake of HQE was somewhat effective to effective, with a more positive inclination from Saskatchewan policy makers. Some of the reasons why uptake was hindered were that some of the research simply does not exist, the issues of context and values were not adequately addressed, there are conflicting goals within government, media would inflame a controversy around an issue, and the policy-making apparatus was fragmented. HQE appeared to respond to narrowly focused questions and issues and miss out the broad ones. The displacement of the important issues with the urgent also appeared to hamper the use of HQE.

Researcher

What is HQE?

Researchers in Alberta and Saskatchewan were consistent in their characterization of what constituted HQE: it had to be scientifically validated, relevant, generalizable, objective (bias removed), and transparent and it should use an appropriate method for the question. Researchers spoke to the internationally accepted hierarchies of evidence and the fact that in policy making, the most rigorous form of scientific experimentation could rarely be used: double-blinded, RCTs. One researcher pointed out that public opinion polls, media reports, and unpublished studies could be HQE as long as they were conducted and reported in a systematic way. Qualitative research methods were also being improved upon, with criteria being developed to differentiate what is good- versus poor-quality qualitative evidence. The demand for their application to the policy field was also increasing.

How is HQE used?

Researchers in both provinces expressed the view that frequently there is a strong temptation by policy makers to provide evidence to a politician that they want to hear and support their position. If a politician or a policy maker receives evidence that supports their point of view, they feel it is good evidence. In the words of a Saskatchewan researcher:

> *...it depends how cynical you are. If they see some research that conforms to their predilections or their already made decisions, they're going to tend to embrace it. Now I'm not quite that cynical. I think... the public service is pretty well educated these days. They have a fair number of research literate people and they also will consult and talk to experts and so on. So I think their view of what is sound research isn't that much different though obviously less nuanced.*

The following quotation from an Alberta researcher provides a nuanced description of the dynamics surrounding the quest that the Alberta government set on to find evidence in support of the "privatization" of health care delivery:

> *...in the case of privatization... we saw on Bill 11 that the government had requested from the bureaucrats that they provide them with evidence which would be supportive of the position the government wanted to pursue ...when the bureaucrats went to try and find the evidence, they couldn't find the evidence that would be supportive of that, or they couldn't find a lot of evidence. So the government didn't get the evidence they needed to support that position. What did they do afterwards? They fired all the bureaucrats. And if you look at where the evidence was coming from, where it was drawn from, it was drawn from the Fraser Institute, who in doing their research on privatization, had taken a very selective approach. So rather than taking a sort of again what would be considered the golden standard in academic terms, which would be the systematic review of all the available evidence and give an assessment of the quality of that evidence and then to say, 'Well, the best quality evidence says this, and the next quality down says this and so down.'...The Fraser Institute basically cherry-picked the body of literature on privatization for what they needed to support the position they were putting forward, and I think that's a good example of how things often work in politics.*

The comments of the researchers illustrate that the temptation to use evidence that supports ones position is a strong one. Objectivity and the removal of bias from HQE are difficult to achieve. This weakness of human nature requires continual diligence in ensuring that one is always prepared to challenge one's assumptions about what is HQE and what is LQE. The researchers in both provinces were consistent in their view of what constituted HQE and they repeated over and over again the need for objectivity (reduction of bias) in the selection of evidence.

The instrumentality of HQE

The researchers from both provinces ranked the use of evidence as being somewhat effective. One said that it could not be ineffective because it does actually happen, so it is somewhere between somewhat effective and ineffective. Alberta and Saskatchewan researchers responded differently to the question of rate of uptake of HQE. Alberta researchers felt that HQE played less of a role in policy making, while their Saskatchewan counterparts identified specific research projects like the long-term care bed study or the hospitalization study, which were conducted to inform the appropriate number of long-term care beds for the province or to look for negative consequences from the hospital closures. The comment was made that staff at Saskatchewan Health were avid readers and followers of the international health policy research literature. Alberta researchers recounted the example of politicians requesting that policy makers, and in turn researchers, find evidence to support a positive position on privatization of health services delivery; when none emerged, senior bureaucrats were transferred from their positions. An example was recounted by one researcher who made a presentation on health reform to an MLA, after which the MLA looked at the researcher and said, *"This is politics; don't confuse me with the facts."* It appears as if there is more tension between the research community and the policy community in Alberta than there is Saskatchewan. This appears to have influenced the degree to which there is an expressed appreciation and respect between the two communities, with there being a healthier relationship in Saskatchewan than in Alberta.

Summary

Researchers in the two provinces were consistent in their characterization of HQE between them, as well as that identified by the other actors. They did add the observation that research methods and findings should be transparent and that the appropriate method be used for the research question. Researchers made reference to the internationally established best practices standards in research and the fact that in the policy arena the most rigorous form of evidence, the RCT, was unavailable as a method to answer questions. Qualitative methods appear to be a complementary approach to quantitative methods, which have begun to standardize their methods and designs so that a level of rigour can be achieved. Qualitative methods could make a significant contribution to the health policy-making field. Researchers confirmed the observation of policy makers that evidence supporting a particular point of view that an individual has is considered to be good evidence by that person. Alberta researchers felt that HQE was not as likely to be adopted in Alberta as Saskatchewan researchers felt was the case in their province. A sentinel event in Alberta involving the politicians and policy makers seeking evidence to support the private delivery of health care services appears to have placed a pall over Alberta researchers' perspectives.

Citizen elite

What is HQE?

Citizen elites from Saskatchewan and Alberta identified several core attributes of what they viewed as HQE. They said it should be objective, measurable, peer reviewed, able to withstand vigorous cross-examination, cost-effective, from a reputable source, relevant, reliable, consistent, reproducible, and generalizable. Several identified the levels of rigour in clinical research and the established grades of evidence from RCTs, through to cohort studies, to control case studies, and case studies. Health care policy making is more likely to be amenable to HQE being created by using methodology from the latter categories.

Policy research does not lend itself to laboratory settings, where one can control the variables. It was observed by several citizen elites that qualitative research methods had reached a level of rigour and sophistication where they can be quite appropriately used to inform health policy questions. It was pointed out that there is a gap within the community of researchers who practise in the quantitative and qualitative fields and they often have to have their research translated to one another.

Several citizen elites felt that characteristics of HQE were that it should be repeatable across cultures, examine multiple stakeholders rather than a single source, be shared among countries, and stimulate discussion groups. A citizen elite also made the observation that the search for a "single magic bullet" to address issues in health care policy making was likely futile. HQE should also include performance measures of the health care system that can be put in front of the public.

Communicating the information in a way that is understood by the public was identified as being very important. The evidence should also be generated by autonomous agencies that are free of influence of government, interest groups, or the advocacy of professions. One citizen elite did make the observation that a politician is likely to consider what will get him/her reelected as HQE.

How is HQE used?

In regard to the uptake of HQE, the judgment of citizen elites in both provinces ranged from ineffective to somewhat effective, depending on the issue being examined. An Alberta citizen elite felt that in some areas, like health promotion and disease prevention, adoption was very effective. In areas of infrastructure, funding, and accountability, it was considered effective and in the area of sustainability of the health system, it was considered ineffective. One Alberta citizen elite recounted the following:

> *I would say, probably ineffective... but the overlay of partisan politics so colors the information that sometimes the information is molded to fit the partisan politics. And, so I think that oftentimes there is evidence that might be there that is cherry picked so that it fits the party view rather than trying to present the open information. And a good example of that is the whole idea about cuts to health care in the mid-1990s. During the early 1993 when Klein came in, he kept saying health care spending is out of control and so forth. If you look at health care spending at the time, it was not out of control...We were only spending about 25% of the budget at that time on health care. But they cut the budgets by a third anyway, across the board, all the budgets of government and so forth. And then he dumped it all back in at the end of the 1990s, helter-skelter. I mean, with no, no planning whatsoever. I think that those types of decisions are extremely negative for the health care system and for that matter, for many of the public systems where the systems rely on public funding. Education, health, transportation, infrastructure – those types of things I think are very damaged by those kinds of decisions.*

Several of the citizen elites from both provinces recounted their experience that often politics required that evidence fit the partisan politics of the day and evidence would be "cherry picked" to fit the desired outcome. At other times, the evidence would be available but it was a matter of waiting for the "window of opportunity" to be able to use it in policy making.

The instrumentality of HQE

In respect to the overall comments of the citizen elites, they were predominantly negative; however, there were some areas where they felt there was some positive uptake. One respondent characterized it as a mixed bag but efforts were improving over time.

> *It's increasing. If you look back 20 years, there was very little...a lot of it was based on ideology – politics, interest group pressures. That is gradually changing. We're not there yet, we've got a long ways to go.*

In health promotion and disease prevention, such as people being more conscious of a healthy diet and the need for exercise, the citizen elite felt there was good uptake. A common response was that although evidence may very well be considered, it is often other factors that influence the trajectory of the policy development and implementation. What is considered appropriate at a point in time is also something to consider; for example, in the 1980s, we felt it was necessary to build hospitals throughout rural Alberta to improve the health status of the citizens. We now know that this is not the case. A Saskatchewan citizen elite recounted a similar experience in expositing the tension between doing the right thing and being sensitive to local needs.

> *But let me describe the area that they backed away from for political reasons. Changing the role of small hospitals. The quality of care in small hospitals is unacceptable. The quality of, some of the quality in the larger hospitals is also unacceptable but the quality of care in some of the small hospitals is unacceptable. It's wasting resources. It's staffing those hospitals for acute care when they're really only giving long-term care. And what I said was if those dollars were turned into primary health reform, then you're able to put those dollars to use in that community in providing what I called everyday services you would get better services. And yet the public perceived that recommendation as taking away from their community by changing the, by taking the "H" sign down off the highway. The first question I was asked at the press conference – how many "H" signs on the highways would disappear? So people are still focused unfortunately on the "H" on the highway as a symbol of quality health care. It is not. It is the last thing that is the symbol of quality health care. With the technology today you do not want to be doing surgery in many of those small hospitals.*

A second Saskatchewan citizen elite related a similar sentiment:

> *When the government of Saskatchewan grasped the nettle and basically converted 52 hospitals to community health centers, it was the right thing to do. There was some evidence available that we had too many hospitals and too much hospital capacity, but for the communities where the actual conversion occurred, you know, the evidence didn't really matter. They were losing the major economic asset in their community. So, passion and loyalty to their community trumped. It happens every time. And, after that*

> *major system change, to close a hospital now or convert it to some different function, even though we have better evidence I think on which to derive, it would be no easier, you would be having the same battles because it is not perceived by the public as a decision that you can make just on evidence. They would say that into the evidence pool you need to bring factors like economic development and those types of things, rather than just looking at the health system.*

It was also humbling to learn that much of the health care delivery system contributed less to the health status of the population than did other nonmedical factors, such as income and education. We are today more concerned with outcomes and effectiveness even though we do not have good measures of these. People are more likely to ask about what the evidence is that someone is using to support their point of view. One Alberta citizen elite stated:

> *...I think we've made real progress since that time and I think that in ...the last 10, 12, 13 years, that there is now a feeling that all major decisions in the health area need to be evidence based and there has to be reasons given if any situation someone says, "Well we don't need any evidence. This is a self-evident truth. This is axiomatic." And nobody gets away with that any more.*

The fact that governments created organizations like the HSURC and Health Quality Council in Saskatchewan and the AHFMR in Alberta is testament to the fact that governments think that HQE is important – the challenge is to improve its linkage to the policy community.

Summary

Citizen elites identified additional characteristics for HQE: it should be cost-effective, measurable, and reproducible. Citizen elites also raised the opportunity for qualitative research methods to make a contribution; however, they pointed out that often there is as wide a gap between the qualitative and quantitative researchers as there is between the research and policy communities. It was also suggested that HQE should be repeatable across cultures, take into account multiple stakeholders, be shared among countries, and form the basis of discussion groups to debate the evidence. On the point of independence of the creation of HQE, a citizen elite also pointed out that autonomy should not just be from vested interests such as the health care professions but from government itself. The fact that governments are investing in independent organizations like the HSURC, Health Quality Council, and AHFMR are signs that the government feels these agencies are making a positive contribution to health policy making.

Conclusions

There may be disagreements among the epistemic communities about what constitutes HQE, but there are many dimensions about which they agreed and in other cases they identified characteristics that were important to their community. Table 18 categorizes the expressed characteristics of the epistemic communities' understanding of HQE on three dimensions: (a) the source of evidence (source), (b) how well it is connected between the research community and the policy setting (linkage), and (c) how prepared or capable the policy community is to accept it (receptiveness).

Table 18: Epistemic Community's Characteristics of HQE by Its Source, Linkage, and Receptiveness

SOURCE	LINKAGE	RECEPTIVENESS
[illegible] [illegible] [illegible] Independent Objective Empirical Validated Transparent [illegible]	[illegible] Comprehensible Contextual Communicative Consultative	Engaged Timely Nuanced Relevant [illegible] Impact Publicly informed Publicly sensitive [illegible] Generalizable [illegible] Reproducible

The characteristics in Table 18 appear to improve the utility of HQE for policy making. Several of these confirm the findings of research projects reviewed in the literature review. New ones (identified in shading) that are being highlighted by this study are the need for the source to be both reputable and autonomous. Linkages between the researcher community and policy community need to be embedded and appreciative of one another's challenges. Previous research identified the importance of engagement and timeliness; this project identified the need for measurable outcomes to be identified from the impact expected from the research on policy. From the research project point of view, many of the previous findings have been confirmed; however, the necessity for peer review, cross-examination, taking into account multiple perspectives, using an appropriate method, and being cost-effective are highlighted as new challenges.

The perception of what HQE is and how useful it has been in health care policy making is not without considerable debate. What is clear is that many of the informants, particularly the politicians, feel that not enough attention has been given to the context or values associated with the public's perception surrounding a health policy question. It appears as if there are some clear criteria that have been articulated for what should qualify as HQE but one expects that the "devil will be in the details." It is clear, however, that politicians and policy makers expect a broader spectrum of research to be brought to the policy table from the qualitative sciences. In the next chapter, we will look to what motivates the movement toward the use of HQE, the barriers, and other confounding factors.

Table 19 provides a summary comparison of the epistemic communities' perspectives on HQE between Alberta and Saskatchewan. Traditionally, the view of politicians is that they simply act expeditiously in order to maintain their popularity to regain election. This analysis finds that some politicians often wish to undertake a public policy exercise on behalf of the public good, but they are stymied by the fact that the public (or other politician colleagues) may not be knowledgeable about the topic or are lagging behind in their understanding of the issues. This raises a significant question of how the respective epistemic communities can undertake actions in the education of the public that would have them become more sympathetic to policy in support of the public health. This also raises issues as to how the public can be provided an opportunity to become more familiar, involved, and knowledgeable about issues in public health. The politicians in the two provinces differed in what they perceived to be the ideological drivers in their policy development. In Alberta, it was a preoccupation with finding evidence in support of introducing private mechanisms in the health care system, while in Saskatchewan, the attention was directed toward the principles of population health and the wellness model.

This observation is in keeping with the orientation of Alberta politics, which is more marketplace oriented compared with Saskatchewan, which is more communitarian minded. The politicians in both provinces stated that their ideological orientations were not necessarily driven by good evidence but by a philosophical orientation toward a "vision" of what a "good" health care system should look like.

Table 19: Comparison of the Epistemic Communities' Perspectives on HQE in Alberta and Saskatchewan

CHARACTERISTICS	ALBERTA	SASKATCHEWAN
	Politicians	
Same	Source must be reputable, take public sentiment into account, and sellable to the public	
Different	Politicians were desirous of evidence to be found to deal with the future sustainability of health services	Seeking evidence to support the ideal of a health system oriented around health and wellness rather than "sickness"
	Policy Makers	
Same	Research must be autonomous, contextual, relevant, timely, and unbiased	
Different	Policy makers often found themselves in conflict with politicians on issues that made it difficult to "speak truth to power"	Politicians were receptive to policy advice that had synthesized different sources and evidence together into a contextualized mosaic
	Researchers	
Same	Commitment to excellence in the research enterprise to internationally recognized standards of practice and to advance the scope of research to qualitative methods	
Different	Politicians were suspicious of the motives of researchers and disdainful of their ability to understand the "real world"	Politicians and policy makers appeared to respect researchers and vice versa
	Citizen Elites	
Same	Interest groups and interests do attempt to influence policy toward their own ends, but this is improving in recent years with accountability toward measurable outcomes for population health being emphasized – gap between use of quantitative and qualitative methods needs to be closed	
Different	Production of evidence should be independent of government	Focus needs to be moved away from the hospitals in the health system and directed toward primary health care.

Note. HQE = high-quality evidence.

Policy makers in the two provinces were generally in agreement on the requirements for objective and HQE to inform policy; where they differed was in the relationship with the politicians. Politicians in both provinces were providing instructions to policy makers on a strong ideological foundation, marketplace solutions in Alberta and health and wellness in Saskatchewan; however, in the case of Alberta, policy makers were instructed to find evidence in support of something that was relatively weak in HQE. Any evidence that was found had to be handpicked to support that point of view. In Saskatchewan, there was some evidence emerging to support the concepts of delivering health services on a population health model, but it was still in its infancy.

Researchers in both provinces were of a similar view on the importance of HQE to inform policy making. Where the great difference arose was in the relationship between politicians and researchers. In Alberta, politicians viewed researchers with a sense of disdain for their inability to appreciate the issues confronting the politicians. Researchers, on the other hand, saw politicians as simply politically expedient. Both parties, however, pay lip service to the importance of each other's endeavour for policy making. In order that progress is made in building a closer relationship, mechanisms and processes will need to be identified and established that will permit the two epistemic cultures to more closely work together in the public interest.

The citizen elites in both provinces were in agreement on many of the principles of good government being based on a close monitoring of the needs and wishes of the citizens. The citizen elites in Alberta pointed out that in the competition of ideas in the policy-making environment, government should be considered like the other interest groups and interests that are vying for their privileged position. HQE evidence, to be objective, should be created outside of direct government control so that the autonomy and objectivity of researchers can be maximized. The perspective of the Saskatchewan citizen elites was that less emphasis should be placed on the curative institutional structures in society and more on the health promotion and disease prevention initiatives.

Chapter Eight

Motivators, barriers, and confounding factors to HQE

Introduction

Science in the form of positivism and postpositivism has played a significant role in advancing professional practice and policy making in health care. The area of public health scientific findings and how they are dealt with can often have life-or-death consequences for individuals or the broader population – the Canadian tainted blood scandal and the severe acute respiratory syndrome (SARS) deaths in Ontario are examples of where mishandling scientific information has had tragic consequences. The problems inherent in these tragedies were not the lack of science but rather the lack of communication strategies and capacities of organizations and governments to respond in a timely fashion to the crisis. In the previous chapter, it was identified that the four epistemic communities view HQE somewhat differently and place different emphasis on various elements of it. Without a common language and understanding of what HQE is in health care policy making, it is difficult to foresee how progress can be made in the delivery of a public health care system. Often interest groups, ideological interests, or private interests may attempt to influence the public policy process to protect their position in society without regard for the broader public health. The point of this project is to develop a model or theory that will help facilitate the bringing together of all forms of evidence, values, ideology, and opinions (good and bad) into the policy-making process so that the best interests of public health are served. One way to help formulate a way forward is to identify the barriers and confounding factors that exist currently.

In health care policy making, a wide variety of knowledge, interests, ideology, values, beliefs, and attitudes come to inform policy action. The role and influence of traditional scientific evidence has been well grounded, but it has recently come to the fore and is being explored, along with other forms of knowledge, as a way to better inform the health care policy debates. Scientific evidence has had a limited impact on policy making because of one view that politicians and scientists are a part of different epistemic communities or cultures, the politician in the arena of maintaining public credibility and popularity and the scientist seeking objective data, causal linkages, and generalizable findings. Often when a scientific finding is contrary to a political value or ideology, senior bureaucrats find that they have to take into account different considerations to formulate their advice to Ministers. Speaking truth to power becomes a very practical problem that policy makers must be prepared to work with. An Alberta researcher characterized this by stating:

> *...the world of science spends a lot of its preoccupation trying to refine the nature of a question so it becomes answerable. It distills it down, and it makes it as clean and clear and as focused as possible. All the things that, unfortunately, lessen the generalizability of the result once it actually comes out...The political process from what I can understand... tries to take a very broad universal view of all the relevant factors that could be of any importance or consequence...They've got to see the so-called big picture...The scientists put there by the cleanness of the question and the answers that come out and they get visibility. The politicians put there because they appeal to the most number of people.*

The objective of this chapter is to describe the perspectives and responses from the four epistemic communities (politicians, policy makers, researchers, and citizen elites) to questions on issues surrounding the current movement to use HQE to inform policy making and to identify the barriers and other confounding factors to its effective utilization. This is an important question because without a clear understanding of how the various epistemic communities view HQE and the barriers to its use, it is difficult to formulate a way forward. The chapter analyzes the confounding factors and barriers and concludes with a summary of the overarching findings that will set the stage for further discussion and model building for effective policy making.

Politician

What motivates the use of HQE?

The politicians in Alberta and Saskatchewan expressed a positive interest in the movement of using HQE to inform policy making; however, Alberta politicians were most direct in pointing out that the key to a good health care system and policy in support of it is more than scientifically quantifiable information. The example given was that there was no need for research to understand that people preferred to live and age in their homes for as long as possible – all we needed to do was ask them. Obtaining and systematically collating the opinions of seniors living in nursing homes was an important form of evidence that was often overlooked. Saskatchewan politicians spoke about the health care system being much more complex today than it was 20 years ago and so more sophisticated information was needed to respond to the challenges. One example was the question of which health care interventions were most clinically effective and/or cost-effective. The emergence of HQE in the form of HTA as a policy-informing tool has emerged in response to this type of policy question. A significant motivating factor identified by politicians in both provinces was the rate of increasing expenditures on health care over the decades leading up to 1990s and that this was unsustainable over the longer term. Choices would need to be made as to what were "medically necessary" services to be provided for by a publicly funded health care system. The medical curative model of care delivery had reached its zenith in terms of continued improvements to the health status of the citizens and HQE evidence was being sought as to which determinants of health governments should turn to next for continually improving health status. A Saskatchewan politician characterized the motivating factors:

> *The leading policy makers in health care are motivated by the realization that, in the long run, a population health model, on a very holistic approach across society, will lead to a healthier population and, therefore, have a more positive effect on health than simply treating illness...politicians are motivated, firstly, by an acceptance of the population health model. I think most knowledgeable politicians do accept that. Secondly, by their need to do things that makes sense from a budgetary point of view, because they are answerable to the public in terms of rates of spending and taxation and you cannot let the health system simply take all the money that it wants or needs to do the things that it could do, because you couldn't afford it.*

Another factor, the appetite of the public for information and knowledge about health, was also identified as a motivating factor.

Barriers to using HQE

The barriers to using HQE in the making of health care policy range from statements that there are no barriers, to the statement that other factors outside of traditional HQE may be more relevant, to an extensive list of specific encumbrances. The perception that there are no barriers arose from an Alberta politician who also felt that many questions could be answered without undertaking research because the answers may be obvious. Barriers identified by the Alberta informants were that the HQE might not be in a form that is easily comprehendible. A poor connection was identified between the research production capacity and the policy maker's uptake of the findings, resulting in potentially useful research going unused. Problems may arise in that the research question may have been misunderstood by one of the parties or it was not appropriately contextualized. Too much information to absorb was another barrier. The Canada Health Act was seen as a barrier to preventing innovative experiments in health care delivery. In the words of the Alberta politician:

> *...the first major barrier and it happened with the Romanow or Mazankowski Report ... is the Canada Health Act. It is a barrier because it is so extremely rigid in its application to who pays for health care. There's nothing you can do from a financial point of view.*

The same Alberta politician was critical that researchers have a lot of time and knowledge on their hands, yet little appreciation for what the public is thinking or what the political atmosphere is like. They have little practical application they can offer at the end of the day and so getting some practical experience working for an MLA or running for office might be of great service to them. The politician added:

> *...in fairness, lots of them do and they don't run for political office ... what happens ... quite a few of them come over and they become Executive Assistants or researchers for politicians and that is something I would recommend to anybody who ... a young person in University ... spend two or three years working for somebody in the front lines of political life because you learn so much. Then you go back and do your research work and it becomes much more meaningful ... in terms of ... you're always thinking, "Is what I'm doing actually going to be of any use someday?"*

The feedback from Saskatchewan politicians was as diverse but with not as much animosity toward the research community. The barriers were identified as being politics, in other words, bringing people along with ideas that might be new and threatening; governments don't set out to do unpopular things and get defeated so they are forced to deal with what is perceived by the public as urgent. One politician stated:

> *...for politicians, the biggest problem is responding to political – immediate and political imperatives. The one example that I will cite is Question Period in a Provincial House or a Federal House. I almost got to the point where I hated going to Question Period ...because the entire Question Period would be devoted to acute care health examples which the Opposition had. Somebody, for example, had died en route to hospital because the ambulance was a little bit too slow or in hospital... all very tragic in an individual case but when you start to respond to acute care and you want to get the political heat off you, your policy work and your policy program...the much needed other areas of better organizational waitlists: IT, information technology in health, telemedicine... quicker approval of the pharmaceuticals, coordinating pharmaceuticals, these don't ever get the play. So it is the pressure, the day-to-day pressure of governance, which I think, is by far, from a political point of view, the biggest barrier in this regard.*

A sense of insecurity on the part of the public can be a barrier to using HQE because people will often resist a change in which they are uncertain of the future. Vested interests can be a barrier, as they wish to protect their member's interests, for example, unions or professional associations. One Saskatchewan politician felt:

> *...the unions, in particular...have difficulty with change because it will affect some of the things that it is their job to protect... so they will play a role in using politics and public insecurity as their tools to stop the government or the health administrators from making changes at the rate that they might like to see...People do believe what the nurses say or the doctors say ... I am not talking about their regulatory professional groups, but their union groups, like the Union of Nurses or the Medical Association as distinct from the College of Physicians and Surgeons...the public has a tendency to trust them, even if what they are saying is really questionable.*

The public has trust in doctors and nurses and if they choose to speak out in opposition to an issue, the public is likely to side with them. Another barrier for politicians is the focus on the immediate (the urgent displaces the important), for example, question period in the legislature or what is on the front page of the newspaper. The media have tended to focus on the acute care medical system and not the broader health care system. This is often the case with emotionally charged debates that become a barrier for HQE because they tend to be exploited by the media or opposition by taking the focus away from issues of the longer term health status of the population. Politicians understand that fundamental change in policy is difficult to achieve and it does not come from writing papers alone; what seems to work is demonstrating to the public that HQE can result in developing good health policy, for example, trying pilot projects. Timing is also a barrier to the use of HQE because of the immediacy of a situation. The fact that the evidence may not exist in the form of primary studies to synthesize into policy advice may be a barrier. As a Saskatchewan politician noted:

> *I wish to make this point that if we take too much time doing research, the politician will still need to move forward with or without the research. When issues arise and need to be dealt with, if the research cannot be done expeditiously without jeopardizing its quality, politicians may still need to move forward with initiatives without the benefit of research.*

Politicians and policy makers may not be asking researchable questions or they may not know what question to ask. In addition, they may have the evidence but not be able to translate it into what is appropriate consumption for the public interest. A barrier to governments is sometimes to do what is politically expedient; for example, a Saskatchewan politician identified the fact that with the closure of 52 hospitals and their conversion in rural Saskatchewan, the temptation may have been to only close those in the conservative ridings. This was, however, seen to be antithetical to using objective criteria and HQE to inform health care policy. Finally, a Saskatchewan informant pointed out that it would be helpful if researchers were to develop strategic thinking skills that would have them appreciate the complexity of the issues a politician must deal with.

Summary

Politicians were of the view that the need to contain costs and ensure a sustainable health care system into the future, the increasing complexity of health care interventions and systems, and the medical curative model having reached its zenith in continuing to make improvements to the health status of the community were the motivating factors for the creation of HQE to inform policy development to achieve future population health status improvements.

Politicians in Alberta and Saskatchewan identified a string of barriers to the effective use of HQE; however, the sentiment from the Alberta community was somewhat unsympathetic to this being a problem for anyone other than researchers. Alberta politicians felt that other considerations besides HQE might be relevant; HQE is sometimes incomprehensible; there is a poor connection between the policy maker and the researcher; the Canada Health Act stifles innovation; and the form, style, and type of communication is inappropriate for the audience for which it is intended.

Policy maker

What motivates the use of HQE?

The insights of the policy makers in the two provinces are interesting – there are several points that they identify in concert, but on others they are contrary. Policy makers in both provinces also sound a warning of caution not to assume that the perceived increased interest in using HQE to inform policy making is in fact real – it may be a matter of paying lip service to the newest "flavour of the month." In the words of a Saskatchewan policy maker:

> *My observation is that there's actually more talk about it than there's real action on it ...right now there is much less commitment to really have an effective evidence-based decision making than there was even in 91 and 92. Much less...we frequently don't seek it out and even when we get it if it conflicts with some ideology or some position we're taking, a lot of times we just ignore it, just bury it.*

The fiscal imperative

The primary factor identified in both provinces as motivating the movement to using HQE to inform policy making is the fiscal imperative of accountability being demanded by the public for expressions of value for the expenditures of tax dollars. This is linked to a public that demands measures of performance on the effectiveness of the public dollars being expended to ensure that they are resulting in tangible outcomes. This is particularly troublesome with the rapid diffusion of new health care interventions, which may or may not be effective, but the purveyors of the technology benefit from its adoption. Related to this point is the fact that increasing funds have been expended on the health care system and there does not appear to be significant improvements in the health status of the population. In the words of a Saskatchewan policy maker:

> *I think there is a sense of the sector's decisions being very amendable to being skewed by powerful interest groups with very emotional topics I mean the topic is so fundamentally emotional that... I think for policy-makers there is a desire to rise above this sort of hostage taking if you will that can occur so easily by someone saying...people will die if we don't get more of this or a different mix of that. So I think in trying to deal with that there's a real drive to find out... what works.*

The politicization of health care

The second most common reference to what is motivating the use of HQE is the fact that the health system has become so politicized that policy makers need some rational form or foundation on which to counter the vested interests that are attempting to influence health care policy making. Public campaigns by physicians and nurses persuade the government to move in certain directions that protect their interest but under the guise of the public interest do capture the public's attention and sympathy. Increasing the sophistication of decision making beyond simply gut feel is being encouraged because the stakes are so high in respect to making a decision that may not be in the best public interest. For the public to trust the government response to these public campaigns, the "chain of evidence" linking evidence to the decision made will need to be transparent for stakeholders and the public to see. Neither governments nor vested interests wish to be blind-sided by arguments to a policy direction; the preference is to have that debate out in the open, where the facts can be assessed transparently on their own merits.

On the other side is the example of a health professional who may speak out in the media on an issue - about which he or she has no knowledge, and yet has a significant impact on the public – usually without someone willing to argue the other side of the issue, not because the evidence is not there but they (often the government) are unwilling to alienate the professional or his or her peers. The issue around the need for a freestanding children's hospital in Edmonton is an example. During the 1970s and 1980s, leading pediatricians in the city were able to mobilize the communities' sympathy toward the need for a freestanding children's hospital, even though there was an excess of pediatric beds in the city. Part of the issue arose from the passion and emotion with which health care providers deliver their care spilling over into the management of the system, which means that allocation decisions are often made on an emotional basis rather than on a factual one. This can often result in an unwise use of public funds.

One final example identified by policy makers was the "hostage taking" of an issue by a vested interest group, which stated that "*unless we get more MRI into Alberta people will die in the streets.*" To counter this kind of approach, a rational playing field of what are appropriate uses for a publicly funded MRI is substituted for the argument that waiting lists are too long.

Policy makers expressed the view that one needed to be careful and cautious that the current enthusiasm for using HQE actually had traction. Is there something of substance in the commitment to use HQE or is it just a matter of "jumping on the bandwagon"? Two primary motivators for the use of HQE were identified. The first was the fiscal imperative to make wise choices with scare resources. The second was to provide a defendable approach to policy making that was able to counter the politicization that had occurred.

Barriers to using HQE

Policy makers identified timeliness for the delivery of research most often as a barrier to the effective use of HQE in both provinces; however, it was more frequently mentioned in Alberta. An adage recited by an Alberta policy maker was that research questions could be answered by any one or two of the following: cheap, fast, or good, but never all three. This wry humour expresses the frustration on the part of policy makers but also the challenges facing researchers. Timeliness is a barrier because the quality of a research project is often linked to the time it takes. One trades a fast turnaround with lower quality. For example, in a systematic review, some studies may be missed or adequate time not taken to appraise the validity of the primary studies. Some strategy will need to be developed that stratifies the quality of products that come out of a research effort and makes the quality explicitly known to the politicians and policy makers. Warning signs could be placed on quickly produced reports stating, "Use with caution - the primary studies identified in this report have not been systematically appraised." This would allow policy makers to balance the risks of using quickly produced research to make a decision around which the *wrong* choice could have dire consequences or no negative consequences.

Lack of effective linkages between the policy makers and researchers was identified as another barrier. Weak links were identified as resulting in incongruity between policy issues and the researcher's interests, with a different set of incentives operating in the policy world versus the academic research environment.

The failure to communicate clearly the research question and to deliver research findings in a way that was understood by the respective audiences was also a barrier. Saskatchewan policy makers identified a general weakness of researchers' ability to communicate effectively, except in one case, where a specific researcher was credited with brilliant communication skills.

A policy maker also pointed out that research with many caveats and qualifications is not all that useful to a decision maker. A Saskatchewan policy maker noted:

> *... the studies tend to be* [encumbered with] *very many caveats that say ... if we have exactly this situation and exactly this happens, you can conclude this, but more study needs to be done...not understanding again what a policy-maker needs to do ... can I conclude anything about this? My situation isn't exactly the same..."What is the evidence on, you know, fee for service and primary care, because...* [A definitive answer is needed]. *It's very clear. It's not good. It leads to this. It..." He was, he was unequivocal and he was clear and he could, as a decision maker he gave me exactly what I needed.*

This criticism is often symptomatic of the wrong question having been asked. The evidence may not be available and the primary research may not have been done. In spite of uncertainty, there is a need to be able to speak with confidence and authority rather than equivocal language.

Another barrier identified was the high turnover of senior staff in the department, leading to a very unstable environment in which to make progress toward using HQE to inform decisions; actions tend to be expedient. In addition, a policy maker may not be knowledgeable about how to effectively use HQE that has been provided. It is also difficult to change behaviours if people have always resorted to getting one expert opinion to inform a question or issue; it is difficult for them to look to a new source.

Finally, leadership is of importance (at the Minister and Deputy Minister level), demonstrating a commitment to using HQE to inform decisions at the senior levels of government. One of the issues identified by a Saskatchewan policy maker was a query as to why the public was not more insistent on the health care system being based on a much stronger effort of using HQE. One conjecture was perhaps some scepticism on the part of the public that if the government is interested in something they may have an ulterior motive. A second observation is that the public assumes that the policy and decision-making apparatus is based on HQE.

In spite of the enthusiasm, policy makers in both provinces also identified a number of reservations with the belief that the HQE is actually being applied in policy making. Some of these issues are that a paradox is appearing where, on the one hand, the public is becoming increasingly sceptical of expert opinions and public institutions and, at the same time, the demands for and the role of HQE appears to be increasing. One of the other issues identified is that there may be more talk than action about increasing the use of HQE to inform policy. This was particularly a concern once the fiscal pressures are not as much a threat as they were during the nineties. Will the availability of more funds erode the attractiveness of using HQE to inform policy? Health reform may very well be about doing things better in the future; however, putting in place a framework and organization structures for health reform is very different from actually reforming the way health care is delivered and funded. A final observation made was that HQE that suits the needs of politicians has a higher uptake rate than that which does not suit their perspective.

Summary

Policy makers identified the primary motivators for HQE to be the recent movement toward fiscal accountability and performance measurement seeking to demonstrate the effectiveness of health care interventions. Second, the politicization of the health care system makes it very difficult for policy makers to contest the vested interests in an effort to change the status quo without an inordinate accumulation and presentation of HQE. Spokespeople, such as physicians and nurses speaking with passion and emotion about an issue, can successfully overtake the reasoned argument of a bureaucrat who is well armed with HQE. Barriers to the use of HQE were short time lines for production of advice, the interests of policy makers and researchers being incongruous, and HQE evidence being communicated with many qualifications and caveats and in an equivocal manner. The rapid turnover of staff in health ministries was also identified as affecting the capacity of policy makers.

Researcher

What motivates the use of HQE?

Researchers in Alberta and Saskatchewan identified many of the same motivating factors for the increased attention being paid to HQE. At the top of the list was the movement toward greater accountability on the part of the publicly funded health care system to assure value for money. This is tied closely to the motivation arising from fiscal prudence being encouraged to ensure that resource allocation decisions are being made wisely. A Saskatchewan researcher stated:

> *I think there is a genuine appetite in government to improve the quality of their program planning, organization and policy. Auditors General are starting to scrutinize health care a lot more closely from the standpoint of value for money and are your resources in line with your goals? This really never happened before. So both the intellectual developments in the*

> *academy, the whole emphasis on knowledge transfer, as something that ought to be accelerated and increased accountability expectations in government, all conspire to create more of an appetite for high quality research evidence. Obviously it's imperfect and has a long way to go but I think those are the main factors that tend to promote it.*

It was also pointed out that the movement toward using HQE first arose in the health care practice environment, where evidence of inappropriate and unnecessary utilization of health care services and significant regional variation in practices was noted and resulted in a substandard quality of care. The response to this was to establish practice patterns that were based on sound scientific knowledge, where the RCT compared the effectiveness of an intervention against a control. Where RCTs were not possible or available, research designs using cohort analysis, case control, and case studies were the next best forms of evidence. At first the evidence-based practice approach was perceived by those in practice as a threat to and anathema to professional practice, but in time it has earned the reputation of being a best practice.

Those in the practice environments and politicians are now demanding the same level of sophistication and adherence to HQE to inform the policy-making community – what is good for the goose is good for the gander. This is being spurred by the increased uncertainty associated with different health care interventions and their effectiveness, as well as by an increased complexity in the management of the health care system.

Other issues identified were that the agendas of policy makers and researchers were coming together, as policy makers are looking for evidence just as researchers are interested in producing it. One stimulus for this has been the increase in availability of funds to support research. Part of the motivation may also come from the fact that the media have become more sophisticated and are not reporting health care issues as simply being financial or volume problems – there are some serious problems with the quality of care as well. Today's emphasis on knowledge transfer may be stimulating an appetite for evidence to be created and policy makers are seeking it. Finally, it was identified that the desire of science to continually improve things was an innate human characteristic.

Barriers to using HQE

The barriers identified by the researchers were widely dispersed. In Alberta, researchers identified a lack of access to primary data (held by Alberta Health and Wellness), lack of a research capacity to respond to the policy maker's calls, and unrealistic time lines for research to be completed. A Saskatchewan researcher characterized the timeliness issue in this way:

> *Often if the research hasn't anticipated the issue, when the issue gets hot, decisions have to be made irrespective of whether the research is at hand. So that whole process of how do you have a research agenda that is forward looking and that can arrive just in time to inform the decisions is really tricky.*

Another barrier identified was that evidence was not generalizable to a local situation. In the words of an Alberta researcher:

> *...number one as far I'm concerned is ...to generalize the ability of the information to the situation and the decision to be made at hand. It's almost impossible to get the evidence, whether it's research oriented or not, to be sufficiently specific and explicit that it matches the situation at hand...It's even more messy, actually, in public policy because we often don't even agree on the diagnosis let alone the treatment.*

Other barriers identified were lack of funding and a mismatch of the incentives between the applied research requirements of policy makers and what is rewarded in the academic settings that strive for peer-reviewed publications. An Alberta researcher noted the fact that:

> *...often the kind of applied research that government is looking for does not readily lend itself to appear in publication and of course, in terms of the incentives in the academic world, if it's not a peer review publication in most cases it's not considered to be worth it's weight in salt... So there's just no real incentive... if I was just to sum all that up it would be that there really is a mismatch between the incentives in the academic world and the incentives in the political world.*

Researchers from Saskatchewan identified some of the same factors and added that research agencies needed to become active in seeing the research findings through to implementation and creating evidence that the public can understand. Building on this, it was suggested that communicating research in an equivocal voice drives policy makers crazy. In the words of a Saskatchewan researcher:

> *...sometimes the research, and it is the nature of academic research and academic research reporting, is equivocal. There is no definitive answer or it isn't obvious to the people doing the research that Avenue A is better than Avenue B, which frustrates decision-making. They want an answer. Well, if the circumstances are such that there truly is no answer, then what does it mean to say the research should inform decision-making? Maybe it should – maybe it should suggest no change or maybe it should suggest, you know, "Go with your gut" because the research is equivocal.*

A second dimension of this barrier is the issue of communication. A Saskatchewan researcher noted that:

> *...while it's a lot better, while there are a lot more literate producers of research who can actually produce something that is digestible by an intelligent layperson, such as a policy maker, a lot of it remains obscure and many researchers are uncomfortable communicating research findings in a policy context. So they're very pristine about it...They'll say: "I can only tell you about my data and my evidence. Don't ask me about what its policy implications are. That's not my job." Well it's not a comfortable discussion in that circumstance. You need people comfortable in both realms, from both perspectives actually. So I think that's a bit of a barrier.*

One of the barriers to effective use of HQE is that we have not defined what good decision making is and until we do, how will we know when we have it? Public sentiment may not be on board with what the evidence says so there is the need to get the public on side. A Saskatchewan researcher stated:

> *I think that, ultimately policy makers and politicians are rewarded by making good decisions and we don't define, researchers don't define what a good decision is. Ultimately the public does. And if what the public wants is inconsistent with what the research says, it is pretty hard to suggest to the policy makers that you should ignore your public or your publics and simply follow what the research says even though in a totally rational world there would be no disjunction there. So part of it is whether the public actually has an appetite for evidence-based decision making. Because if it doesn't you place the decision makers in a quandary, especially in a democracy where they're accountable to those publics.*

A final observation that was recommended by a Saskatchewan researcher in responding to the barriers was teaching our health sciences students about evidence-based practice and decision making during their education.

Summary

Researchers identified many of the same motivators and added a few new ones. They point out that the evidence-based practice movement originated in an effort to stimulate those delivering health care to continually upgrade their practice skills on the basis of the newest evidence from the research community on what were best practices. Now the expectation was that the policy-making community embrace the same level of rigour in respect to how it makes its policies. The barriers are that in the first instance, politicians were supportive of improving practices but, with the expectation that health care policy would be based on HQE, this reduces the politicians' freedom to exercise their will or values in how it is that health care ought to be delivered. The traditional power of politicians to act arbitrarily is therefore reduced by HQE.

Citizen elites

What motivates the use of HQE?

Citizen elites from both provinces identified a wide variety of factors influencing the current movement toward the use of HQE. One observation by a Saskatchewan citizen was the shock and surprise that most people express when they learn that the health care system may not be evidence based in its practice and decision making. One of the results of this is significant variation in clinical practice with a difference in outcomes and the fact that resources may not be expended wisely. Changing social values and increased education of the public is causing citizens to question institutional structures. Citizens are empowered and taking responsibility for their health. A Saskatchewan citizen elite attributed one motive to:

> *...changing social values in Canada. We do not have the same respect for churches, we do not have the same respect for doctors, we do not have the same respect for lawyers ... the institutions are being questioned. And*

> *that is part, that is good and that is partly a result of the boomer generation I guess coming along and saying, I'm not just going to accept that I get these things when I want them...The generation behind me is questioning tremendously and that is good. And therefore they're starting to ask these questions about quality. They're starting to demand that there be answers and transparency. And transparency is becoming much more important today than it was 25 years ago.*

An Alberta citizen mirrored this view:

> *Another change is the movement towards empowerment of citizens and patients to, rather from a previous concept that the government was responsible for your health to now a concept that evidence indicates that you are the person responsible for your health and that your physician is a partner of yours in your health.*

People are realizing that the health care system is there for them at as low a risk as possible and for their convenience and not the convenience of the providers. An Alberta citizen stated:

> *I think also a feeling that the system...is designed for and should be designed for a priority for the patient and the citizen first and there was a feeling that I think back in the seventies and eighties the system was really designed for MLAs, hospital administrators and people who ran the system, health providers. Whereas the public came to the sense that, no, the most important person should be me.*

The public's expectations are that the principles surrounding the rigour of clinical trials to inform questions of effectiveness about medical interventions with an unbiased approach should be thought about as being relevant to apply to broader public policy questions. An Alberta citizen identified, for example, the increased awareness of the public about the ethical dimensions surrounding health care delivery:

> *I guess the one other interesting way in which that was enhanced was the enhanced knowledge about and discussion of ethics. The ethics issues of say, that relate to no heroic measures to be taken in the event the person is unconscious in a car accident and likely to be so. People started getting interested in these things, started to draw then, judgments, saying, Well, you know, if there is only one kidney available for transplant and one recipient is 89 and probably won't live more than 6 weeks and that could be used for a 19 year old youngster and great promise, we'd better work and have the evidence as to what's going on here in these highly costly*

> *procedures. Because with the evidence we can help our way out of this ethical dilemma.*

There is more evidence around than there used to be and there are more champions encouraging its utilization in the health care system. There is more HQE available to everyone, even to the public, and it is written such that it is comprehensible to the general public. A Saskatchewan citizen observed the power of reducing the asymmetry of information between health care professionals and the public:

> *I tried to...get this information out to the public. Because if you can get the public – and don't underestimate the public's intelligence – the public today are way brighter and smarter than we professionals would have ever liked to believe. But get the information out...The public can go on the Internet and either they will get good information or maybe bad information. But a G.P. today calls Mr. Smith and says you've got such and such a cancer of blah blah blah, and it's this kind of cancer. Come back in three weeks I'd like to see you. When Mr. Smith comes back in three weeks, Mr. Smith's been on the Internet. He has found out the treatment for that cancer in Houston, Texas, he's found out that's the best place. He's found out how it compares to this and that. Even today with the information and that patient goes back in to that doctor knowing way more about that issue than the doctor does.*

There is more emphasis being placed on measurement and it being oriented toward outcomes of effectiveness for the interventions. Finally policy makers have been encouraging evidence-based practice from the health care providers so it seems axiomatic that the providers and citizens would now expect a high standard of behaviour from the policy makers as well. A Saskatchewan citizen offered that:

> *I think to the extent that that is happening and it's still incremental process, I think that it's interesting that when policy makers have, for some time, strongly encouraged people who are providing health care to be evidence-based in their provision of health care, it is pretty axiomatic that some people will in turn say "and are you evidence-based in your decision-making." So, to some extent, I think that the evidence-based movement had its roots more in the actual clinical practice and then, as that has gained more credibility, it begins to impact in other spheres. So I think that is a significant motivator.*

Barriers to using HQE

The most common citizen elite's view on barriers to the use of HQE in both provinces is the politicization of health care. This involves such things as having the evidence run contrary to a politician's beliefs or the political ideology of the day. One of the informants characterized this as "vested interest gridlock," an inability to accommodate changes using HQE because of the influence to maintain the status quo. This is not just restricted to doctors and nurses. The government is highly implicated as well. A Saskatchewan citizen stated:

> *I am not talking here just about money, but I am talking about maintaining control and power. So, on primary care reform, I mean you have agencies boldly saying to the government "look, we can totally block this or we can help ... unless you work with us, nothing is going to happen." And that is sheer power of politics. I think that is unfortunate. But, it is reality. So, I think that as the quality of evidence and the capacity to explain it in an understandable way to the public improves, I think it disarms the potential for vested interests and ideology to trump. But, sometimes, it is still the case that it will trump.*

One informant also made reference to the occasional intrusion of politicians into the policy shops in government running interference on issues. This compromises the ability for objectivity on the research effort. A Saskatchewan citizen elite relayed his experience:

> *...when I started working on all of this stuff I was abhorred by some political hack in the Minister's Office calling the Director of Policy, or actually calling a research analyst and saying "give me information on this." And I think that this has happened across the country where the line between the public service and the political school has been compromised. Some politicians are very, very good ... they understand that line. But we have a lot of people, now, in government, who are elected as politicians who frankly don't understand and, as a result, they get this power piece and they get the political hacks that are cousins or brothers or people in their local constituency, and they get them working, and they say "I want this" and those people don't care what they do to get it.*

Other barriers identified were lack of good primary data; a fixation on responding to immediate issues; and losing sight of the longer term decimation during the period of cost containment of the policy-making capacity in government who can work with evidence. Another observation was that the linkages between the policy shops in government and the independent research agencies could be improved. Finally, the lack of investment by government in research was identified as a barrier but this appeared to be improving.

If public policy comes into a conflict between what the public opinion sentiment is saying and what the evidence is saying, it is more than likely that the politicians will side with the public opinion. So the challenge is how to bring along public opinion to be receptive to the emerging research evidence. A Saskatchewan citizen elite stated:

> *...the principal barrier is still the fact that often public policy in any sector, but we are now talking about health, is highly sensitive to unwashed public opinion, and so there is not infrequently a clash between evidence and public opinion on a particular issue. If you are having to make policy decisions that could impact on political fate, then public opinion is going to be a significant driver. Where that is inconsistent with evidence...that's a barrier.*

Another significant barrier is the lack of any measurable metrics, particularly on effectiveness and outcomes, as to how well we are doing in the use of HQE and whether it makes any difference in the overall health of our citizens. This information should be made available to the public.

The confounding factors identified by the citizen elites cover a wide range of issues. One that was raised by an Alberta citizen elite is that the structures and processes of government do not lend themselves to facilitating the use of HQE to inform decisions. The institutional structures tend to favour such characteristics as self-interest, vested interests, opinions, myths, community self-interest, political expediency, public opinion, individual bias, ignorance, professional self-interest, history, and tradition. One of the informants talked about things getting tied together (negotiations with the physicians are tied in with primary care reform) and nothing happening on the reform front until negotiations are complete. One issue is held hostage to achieve another. The Standing Priorities Committee was identified in Alberta as being one structure and process that takes away from the policy formulation function of the legislature: it becomes more of a private consultation of government to gain input without adequate thought to differentiating between HQE and LQE. It was suggested that more champions to advance the EBDM effort were necessary.

The lack of appreciation for the role of prevention and health promotion is another barrier for HQE to get traction with the public. There is also an intrinsic bias in society to assume, without being critical of the cost implications, that anything that arrives from science must be automatically good.

Summary

Citizen elites identified several factors encouraging the current movement. A Saskatchewan citizen elite expressed the astonishment felt when first made aware that health care system practices are not based on best evidence. To add insult to injury, the delivery is not based on best practice either, so one motivating factor is to introduce best practices. One prominent barrier identified by the citizens is the politicization of health care, leading to a vested interest gridlock preventing real health reform from taking place. Other factors inhibiting the use of HQE are interference from politicians in the work of policy shops, a lack of metrics defining success, and a fixation on the urgent rather than the important.

Conclusion

The motivators for the use of HQE in health care policy making are based on the modern neoliberal tendencies for finding mechanisms to control what appear to be the unchecked growth rates of provincial funds on health care expenditures. This motive, linked to the contemporary fixation on accountability, performance measures, and "value for money," is driving the health care policy community to adopt mechanisms of postpositivistic science to address questions of choice in health policy. The currency of the population health model, where improvements to the health status of a community are seen to be based on the fundamental needs of financial security, education, housing, and rewarding employment, is taking the focus away from curative elements of the health system to the broader societal needs.

In Alberta, the motivators are a political philosophy that encourages citizens to take more responsibility for their own health, as well as the realization that the health care system is there to meet the public's needs rather than the needs of the health system. In Saskatchewan, a primary motivator identified for the encouragement for using HQE is the reduction in the asymmetry in the knowledge of the public on health care issues. The motivators identified in Table 20 will be used to inform a model for policy making that will provide an avenue of response.

Table 20: Motivators in the Use of HQE

CHARACTERISTICS	ALBERTA	SASKATCHEWAN
	Politicians	
Same	Increasing rates of expenditure on health care, currency of the population health model, public appetite for knowledge on health	
Different	More than HQE is necessary for policy making	Increasing complexity of health system
	Policy Makers	
Same	Budgets, accountability of tax expenditures to public for measures of value, hostage taking of issues, politicization of health care, rational response needed to counter vested interests	
Different	Budgets and accountability	Leadership on the part of the Minister and Deputy Minister to rely on HQE
	Researchers	
Same	Accountability and value for money, evidence-based practice is followed in health care delivery so why not decision and policy making	
Different	Same	Same
	Citizen Elite	
Same	Questioning public, transparency of health care delivery and the knowledge it is based upon	
Different	Empowerment of citizens to take responsibility for their health; the health care system is there to serve their needs, not the other way around; and ethical dimensions emerging in health care require sophisticated thinking and analysis	Reduce the asymmetry in knowledge with the public and provide evidence or measurements that demonstrate the effectiveness of the health care system

Note. HQE = high-quality evidence.

Table 21 compares the epistemic communities' perspectives on barriers in Alberta and Saskatchewan in the effective use of HQE in policy making. By and large, the perspectives of the two provinces are similar except for the fact that there is a palatable animosity between the politicians and research community in Alberta, which does not appear to exist in Saskatchewan. This will make the challenge of building the bridges in Alberta greater. Politicians in Saskatchewan were more concerned with the displacement of the "urgent," with the "important" in dealing with health care issues, as well as not getting "too far ahead of the public" on issues and their remediation. Policy makers in both provinces were concerned about a hollow commitment to HQE, the timeliness with which the research community could respond to issues, and the divergent incentives in the two epistemic communities. Researchers in the two provinces identified many of the same barriers, with Alberta researchers being particularly concerned with a lack of access to data from government and a lack of capacity to conduct the research. In Saskatchewan, the concerns were with timeliness and little opportunity for policy makers and researchers to follow a project through from inception to implementation. Citizen elites identified the politicization of health care, vested interest gridlock, interference in policy shops, and a lack of means to measure success in outcomes as major barriers.

Table 21: Comparison of the Epistemic Communities' Perspectives on Barriers in Alberta and Saskatchewan

CHARACTERISTICS	ALBERTA	SASKATCHEWAN
	Politicians	
Same	Research is not comprehensible, evidence may not exist, public insecurity, protection of vested interests, not contextual, wrong questions being asked	
Different	Animosity between researchers and politicians, Canada Health Act, poor linkages	Politics – urgent displaces the important, not getting too far ahead of the public
	Policy Makers	
Same	Paying lip service to use of HQE, timeliness, differing incentives	
Different	Quality and timeliness tradeoff	Research with multiple caveats and turnover of staff
	Researchers	
Same	Context specific, inadequate funding to support research, misaligned incentives, poor communication skills, no definition of "best practice" in policy making	
Different	Data inaccessible from government and inadequate competence and capacity to do research	Time available, no opportunity to follow project from inception to implementation
	Citizen Elite	
Same	Politicization of health care, vested interest grid lock, interference in policy shops, fixation on the urgent rather than important, and a lack of metrics on measuring success	
Different	Lack of data, reduction in policy analysis capacity, poor linkages, hostage taking of issues, institutional barriers	Bringing along public opinion and inconsistency between best evidence and public opinion

Note. HQE = high-quality evidence.

Table 22 synthesizes the primary barriers identified between the two provinces and among the epistemic communities, which will need to be addressed by the model that is developed in chapter 11.

Table 22: Summary of Barriers Perceived by the Actors Grouped by Lavis' Construct of Idea, Interest, and Institutional Barriers

	IDEAS	INTERESTS	INSTITUTIONAL
Politician	Mutual animosity Competing ideas Incomprehensible No context Poor question Untranslatable	Insecurity of public Competing Politics Vested	Timing Poor timing Poor communication Canada Health Act Poorly informed researchers Politics Urgent displace important
Policy maker	Comprehension Equivocal advice Scepticism	Incentives differ Perverse incentives What do they really want?	Time lines unrealistic Expert opinion Expensive Lack of linkage Lack of leadership Poor communication Primary research unavailable Uncertainty Reduced capacity Turnover of staff
Researcher	Generalizability Public comprehension Communication	Diverse Incongruent	Education of students Lack of access to data Capacity to respond Unrealistic time lines Funding Mismatch incentives Continuity research to policy Communication Define good policy making
Citizen Elite	Interference Conflict Lack of traction	Politicization Gridlock Hostage taking	Urgent rather than important Downsizing Poor linkages No metrics Structure not conducive HQE not valued

Note. HQE = high-quality evidence.

The new barriers that this study has identified are the animosity between researchers and policy makers, insecurity of the public, Canada Health Act, equivocal advice, scepticism, cost of research, lack of leadership, reduced capacity in policy making, turnover of staff, education of students, lack of access to data, poor capacity to respond, defining “good” policy making, and no metrics of the outcomes. Strategies to respond to these barriers will be developed in chapters 11 and 12.

Chapter Nine

What are the sources of HQE and LQE and how should it be produced?

Introduction

In the previous two chapters, the perspectives of the four epistemic communities on the questions of what constitutes HQE and how it is used, both effectively and ineffectively, as well as the barriers to its use, were described. In this chapter, the objective is to determine whether the source of the HQE or LQE makes a difference in its quality and usability for health care policy making. This is an important question because, as we have demonstrated, one of the most highly prized characteristics of HQE is that it is highly objective and free of interference from interests, which may be attempting to sway it in a certain direction. One of the most cherished characteristics of a research effort is its credibility and reputation. One of the preconditions for the autonomy or objectivity of the work is it being conducted free of interference. We established in the previous chapter that evidence produced within an organization that has a vested interest in the outcome (like an interest group or government) of a study is likely suspect. The research may well be high quality and objective, but there will be the appearance that it is beholden to sympathy toward the organization that commissioned it. The task in the present chapter is to untangle what the various sources of HQE and LQE are and how they are produced. The results of the interviews will be analyzed with a view to providing an approach of how the production of HQE for health care policy making can be generated so as to maximize its quality and potential for contributing to the advancement of the populations' health. The chapter concludes with several overarching concepts that will set the stage for further analysis and model building for policy making.

Politician

Sources of HQE

Politicians in the two provinces look to their own departments as sources of HQE, but also to academics at the universities in the provinces and agencies such as AHFMR, HSURC, Saskatchewan Institute of Public Policy, Health Quality Council (previously the HSURC), and Saskatchewan Population Health and Evaluation Research Unit, as well as similar agencies in other provinces and countries. In Alberta, politicians made mention of NGOs, the Centers for Disease Control and Prevention, and the World Health Organization as reputable sources. An Alberta politician proffered that a researcher with experience in public affairs and/or a political sensitivity for issues was often far more helpful in providing relevant evidence than someone without that experience. Alberta politicians identified opinion polls as important sources of HQE; however, they qualified this by saying they had to be methodologically sound to be useful. In Saskatchewan, the only other sources identified were symposiums or forums organized to stimulate discussion and debate around specific health care issues or initiatives in health care reform. The reason for support of this technique is that often public debate on the issues helps to move it forward on the agenda in a participatory and transparent fashion. The Saskatchewan politician felt that government had a responsibility to continue challenging the public sentiment with new knowledge that would advance their health status.

Sources of LQE

When asked about poor sources of evidence, Alberta politicians identified poor polling techniques and not taking public expectations and sentiment into account when dealing with an issue. Saskatchewan politicians identified unions and professional groups whose job it was to protect the interests of their membership as being evidence that would likely have a biased perspective communicated in it. This was not meant to indict the evidence but rather to point out that the information, as all information, must be looked at critically. The Saskatchewan politician stated:

> *They are part of the system and, if they don't stand up for their members, nobody else is going to I believe in collective bargaining rights and all*

> *that, but it is like they play a legitimate role but you must acknowledge the role they play and there is sort of a push/pull thing, you know. They are part of the system and, if they don't stand up for their members, nobody else is going to.*

The politician further differentiated the role of the union or professional association from that of an organization such as a professional college that regulates the profession in society:

> *...the Saskatchewan Registered Nurses' Association or the College of Physicians and Surgeons ... I don't think they see that as their role ... to protect job rights of individuals. I think they see their role as to ask ... as professions, how do we advance the public interest. I think that they accept that the reason they are self-governing professions is because the governments have decided that that is the best way to achieve the public interest ... So they take that seriously.*

Information arising from Opposition members might be another source of poor evidence, as they would be interested in creating a certain perception with their information. The evidence put forward by advocacy groups needs to be looked at carefully to determine what the motivation and perspective of the group might be. This is particularly the case when the advocacy group is lobbying the government for a certain award. A Saskatchewan politician also pointed out that often information or evidence from the nurses or physicians, although it may promulgate professional interest, can have a higher impact on the public than politicians can. The politician attributes this to the fact that in contemporary society, physicians and nurses have higher credibility rankings in the eyes of the public than do politicians.

Production of HQE

On the question of whether HQE to inform health care policy making should be produced at arm's length from government or other vested interests in society, there was not an unequivocal position stated. In Alberta, opinion ranged from pointing out that there was an absence of the capacity or capability outside of government to do the research (at an affordable cost) to the opinion that there is a benefit of perceptual independence from having the research done outside. An Alberta politician felt that the knowledge and capacity was lacking in government to do the work – contrary to the previous observation. This politician was aware that the staffing complement in the health department had been reduced significantly during the 1990s when the government was undertaking health reform. An Alberta politician had the view that whoever is doing the research should be made aware that there is an expected implementation activity after the research findings have been completed. The researcher should be prepared to participate in the implementation of the findings – particularly as they relate to the publics' and politicians' perception. The politician felt that the role of a researcher should be extended beyond their immediate setting so that they experience the challenges and issues associated with the implementation of their findings. These observations highlight the tension that is created by virtue of the knowledge creation activity, which is encouraged to be independent but at the same time close enough to the community that the research will resonate and have traction with those who have responsibility for implementation.

In Saskatchewan, the view was that a sense of interdependence needed to be nurtured among and between all of the parties because they had different responsibilities to fulfill. Researchers needed to be independent of policy makers and policy makers needed to be independent of the politicians, who in turn were there to represent the interests of their citizens. Since they are all professionals, it is expected that they would ensure that their respective scopes of responsibility were carried out without any undue or inappropriate influence. In Saskatchewan, there was a sense that each of the parties could exercise their independence but still be able to relate in a cooperative fashion; this is captured in the following quotation.

On the question of autonomy, a Saskatchewan politician noted:

> *Well, I'm not so sure. You certainly want the people that produce the evidence and studies to be independent but I think the policy makers are, you know, need the same kind of independence from the politicians in the sense that they advise politicians and the politicians decide whether they can follow the advice. I think that the people who produce the evidence and the health care policy makers ... I wouldn't be concerned about an arms - length relationship. I think of them all as ... they are professionals and they are all going in at the same direction.*

The weakness in this observation is that as long as all parties are respectful of the boundaries of their roles, then this approach of mutual respect can work quite well. However, as was pointed out in other interviews earlier, the politicization of health care has led to an extremely complex environment where influences are very often brought to bear on circumstances where it may be inappropriate. One example was the request by the Alberta government to see evidence produced in support of identifying the benefits of privatization of health care – without asking the question more objectively.

Two Saskatchewan politicians recognized a need for both internal and external capacity to produce HQE. One Saskatchewan politician stated:

> *I think it needs to be both. I think you do need it in house because you need to react very quickly to things and right now, outside agencies are still focused on the perfect product. The perfect product may take too long and politicians may be required to move before it is produced. So what is needed then is the ability in-house to do some research and couple that with the ability outside to do a more detailed product.*

This observation provides a balanced perspective that considers the need for timeliness to be taken into account in undertaking the production of new knowledge to inform a policy question. The other characteristic of knowledge production that this underlines is that the management of the creation of knowledge is a complex and time-consuming activity; developing the requests for proposals and invitations for response from the research community may take a great deal of time and expertise to get right. The knowledge and skills of those in the government department will be necessary to manage these activities to ensure that they are done well. Even if the production of evidence is not conducted in a government department, it must still be managed accordingly. A Saskatchewan politician felt that:

> *...there needs to be an effective and efficient liaison between the research body and the politician. There needs to be a closer relationship between research entities and policy makers. They shouldn't be so separate in their agendas. However, I would not want to see it all done in-house. That would be a mistake. Some things may need, by their very nature, to*

> *be outsourced. So I am really talking about different kinds of research with different goals and objectives. We need to make that distinction and we need to know how to distinguish what can be done in house and what needs to be outsourced.*

Using this approach for quick responses (issues that arise during question period are certain to be urgent rather than important) would likely need to rely on the internal capacity of the department, while projects that required more deliberative research methods could be apportioned to external agencies. The issue is that decisions would have to be made by politicians whether the evidence was there or not; a way forward would be to differentiate between the quality versus timeliness tradeoff and make a conscious decision as to whether the increased risk from not getting the best answer was worth the reduced time to conduct the research. It is often said in policy circles of researchers that "perfection is the enemy of the good," meaning that if the deadline for using information is passed, regardless of how good it is, the fact that it could not be used to inform the question is a serious problem.

Another way of formulating an approach to the problem would be to determine how much evidence of a high quality exists in the literature to address the problem. If there is adequate information with multiple perspectives, it may be adequate to inform the question and an internal initiative may serve the needs. However, if there is very little HQE, in other words, the primary research does not exist to inform a synthesized policy response, then an appropriate way forward would be to offer research grants and awards to compete for primary research project(s) that would provide the evidence to inform the policy question.

Another point of view from Saskatchewan was that the public likely does not differentiate between whether the researchers are independent or not – particularly if they do not agree with the research findings. This was a view not shared with other politicians. One point of view against independent research was the creation of yet another silo in the health care system, which has been identified as one of the perennial problems of the segments of the health care system communicating poorly with one another. Separating policy makers and researchers is likely to render the enterprise even further into irrelevance, in this politician's view. This politician implored the need for researchers and policy makers to sit at the same table. In his words:

> *I believe that ...one of the biggest impediments to a good health care policy in this country... is the fact that there are too many silos. In adding yet another one, a silo where you have researchers independent and at arm's length ...doesn't help things, it complicates matters. The reality is... what's really needed is a high quality evidence and research which is recognized as such, which doesn't necessarily dilute its integrity of research in order to satisfy health care policy making but sits around the table to hear at least concerns of the health policy makers. Presumably those would be the politicians and the bureaucrats, right? And the two of them hearing each other's sides can only ...be helped in the approach.*

A second politician echoed this view. One politician did make the comment that sometimes research needs to be outsourced for the purposes of ensuring for the public and all stakeholders that there is independence in the work being carried out.

Summary

Politicians in both provinces identified their own government departments, research agencies, and university academics as the primary sources of HQE. These extended beyond the boundaries of the provinces to other countries. In respect to poor-quality evidence, politicians in Alberta pointed to poor polling techniques or information that had not taken the public sentiment into account. Saskatchewan politicians pointed to any information that comes with a built-in agenda, which might be put forward by a professional association or advocacy group. On the question of whether HQE should be produced in government or by independent agencies at arm's length from government and other vested interests, there was no unanimous point of view. It did appear as if there was a need for HQE to be produced within a government department in response to issues that had a tight time line. Projects that could take longer and be more extensively researched could be assigned to independent external agencies. There was a strong feeling that creating more silos to bridge between policy and research was perhaps unwise and mechanisms should be established to encourage a closer link between the two. The value of independent advice was underscored, citing that independence and objectivity of researchers from policy makers was as important as the independence of policy makers from politicians.

Policy maker

Sources of HQE

Policy makers in the two provinces identified staff within their own departments as sources of HQE to conduct literature searches or to search the Web for information. A Saskatchewan policy maker noted:

> *In some ways we have a history of doing some things in house and what I would say here is that the advantage of in house people is that they really understand the data. They really understand its limitations...I think the problem with it inherently though is the government is viewed, because of its funding role, the work can be very strong but it's easy to discredit...they have an agenda. So, I think the trade off is always, if you want the work to be influential, it may be more, it may be important to have the work done outside.*

This observation speaks to the expertise and knowledge that is contained within the department of health, but it also recognizes that the perception of independence is very important. One way to ameliorate this dilemma is to utilize in-house expertise to help develop and guide the research agenda for the health system but to leave the actual primary and secondary research to be conducted by outside agencies and universities that would respond to the calls for proposals. This would require that new mechanisms and processes be established to ensure that there is relevancy and currency of the research agenda.

The Saskatchewan policy maker pointed out that the "fresh look" that someone from outside can bring to a policy conundrum can also add legitimacy to it for the public. Policy makers from both provinces identified university researchers who have developed an expertise or niche in a topic area they are interested in and that often have international reputations on that topic. Other sources of HQE identified were the peer review literature, as well as agencies such as the CHSRF and the Romanow Commission, specifically the background and discussion papers. One other source of HQE identified was networking with people who are keeping abreast of the advances in the HSR field.

Sources of LQE

Alberta and Saskatchewan policy makers identified the Fraser Institute as a source of questionable information and Alberta policy makers added the Parkland Institute as a second. An Alberta policy maker stated:

> *In this province anything from the Parkland Institute and in other provinces ironically it would be the opposite. Anything from the Fraser Institute is automatically suspect in certain parts of B.C. And personally there are parts of Fraser that I do not have a problem with their credibility. There are others that I, but this may relate to which things I have more experience with. There are other parts that I'm absolutely horrified at, you know. But their stuff is always open to debate. Parkland has done some reasonably good work on very little money but Ralph Klein automatically dismisses anything that comes from Parkland even when it's credible. Yeah, so there are always these problems of political affiliation.*

This observation underlines how fickle and vulnerable policy makers may be about adjudicating on the quality of research evidence from what are perceived as partisan sources. This raises an important issue when the government in power favours a specific ideological orientation on an issue. The Fraser Institute has a reputation of promoting the role of competitive markets in providing for the economic and social well-being of Canadians and therefore promulgates opportunities for where the marketplace might provide solutions to the future reform of health care systems. The Parkland Institute at the University of Alberta, on the other hand, operates in a critical but nonpartisan fashion on matters of public policy. The criticism by the Parkland Institute of the Alberta government's approach to health reform causes the Premier of the province to automatically dismiss it because it is critical of his government's policy action. This issue underlines the importance for the development and application of an agreed upon framework and criteria for differentiating what is good-quality evidence and what is not. These criteria exist within the knowledge creation settings, but they are not well known in the policy-making circles and it will be the challenge of this project to identify how politicians and policy makers can use criteria to separate the wheat from the chaff in health care policy debates.

Policy makers from both provinces identified the evidence originating from the media or advocacy or ideologically based groups (this again was qualified not to prejudge the evidence but to check its validity) as a potential source of LQE. An Alberta policy maker stated:

> *We're better aware of how things get distorted in the media. Some of the stuff we get from advocacy groups, you know you might want to dig a little bit deeper and get some of the information verified. It's all about potential bias. Sources of evidence that you know are highly likely to have quite a strong bias for a whole variety of reasons are generally not considered good sources of information. But at the same time, for example, the Expert Advisory Panel – we encouraged them to get information from a variety of sources because we wanted the professions that were being reviewed to have their say. We made sure they had access to that information.*

This quotation from the Alberta policy maker underlines the importance of, on the one hand, interrogating the evidence that is put forward and separating the good advice from the bad but, on the other, providing the public and vested interests with an opportunity to have expressed their concerns and issues transparently and openly in society so that it can be judged on its own merits.

When asked for examples of poor-quality research, policy makers identified several. One previously mentioned was the Fraser Institute, which carries out an annual wait list survey across Canada. This is a survey of loosely structured opinions and it is not externally peer reviewed. A second example was a project undertaken to identify the appropriate ratio of MRI to population in Alberta and it was the provincial association of radiologists that was asked to conduct the review. It might be that radiologists have a vested interest in the availability of their technology for reasons other than access for citizens. A Saskatchewan policy maker noted:

> *So for example there was a piece of work done in Alberta ...on MRI scans per thousand and what was the appropriate standard... they came up with a very different number than everyone had been looking at. Everyone had looked at 8 scans per ... thousand...and they came up with 24 ... it was done basically by the radiology section. I mean there was no ...evidence about what was the outcome to a population's health.*

Alberta policy makers expressed a concern with the kind of data that was utilized in some projects, for example, using data to inform questions for which the data was never intended. A Saskatchewan policy maker identified a concern with survey data being presented without the background or backup for how the survey was conducted. Two Saskatchewan policy makers identified the pharmaceutical industry as well as some universities, which may suppress information from their clinical trials because the results are negative. The example cited was the case of Dr. Olivieri at the University of Toronto and Sick Kids Hospital in Toronto. Other sources of poor-quality evidence were the daily newspaper, government Web sites, and poor sources on the Internet. These observations underline the importance of policy makers to develop criteria by which to appraise the quality of the evidence coming from these various sources. The management of knowledge and what counts as knowledge to inform the health care policy enterprise will become a major challenge to the policy-making community.

Production of HQE

This section attempts to get to an understanding of policy makers' views as to whether the production of HQE needed to be independent of government or other vested interests in society. All of the policy makers in Alberta and Saskatchewan generally felt the evidence should be created outside of government, except in circumstances where there was significant advantage to doing it internally. A Saskatchewan policy maker stated:

> *...if "arms length" means that it is an independent-thinking body - yes. I think there should be a distance for a whole bunch of reasons I think we touched on. For one thing, you are going to get purer research and outcomes because there is nothing predefined and, secondly, and maybe more importantly, when you are using the evidence to make a change that has resistance, it has a lot more impact, as I was saying, than a politician or a bureaucrat. I mean, somebody from the University or somebody from HSURC says so, then I may not agree, but it is hard to argue...On the other hand, I don't support these research places that cut themselves right off from everything. I think that is too far of a stretch and I don't think they live in the real world and they don't understand.*

Supporting a previous observation, this approach would have straightforward questions answered internally but the really big questions like reform needed an independent source. One informant stated, "*If autonomous means freethinking then yes*!" Reasons for doing it externally included increased objectivity and removal of bias (perceived and real), deliverables can be clearly spelled out in a contract, and independent work has more chance of having an impact. An Alberta policy maker did, however, offer a caution:

> *I definitely see value in some high quality evidence being generated at arms length, obviously. There needs to be a type of bridge and the scope of this high quality evidence needs to broaden because if you think about, for example, decisions around whether or not to publicly fund certain treatments and procedures the evidence just isn't there, right? Because the focus is limited to the clinical effectiveness of it...So absolutely I see the value in arms length agencies generating high quality evidence but without the tighter bridge it doesn't have the impact it could.*

A pragmatic reason for external HQE was that if cost cutting is necessary in the future, researchers would not be a target for staff layoffs, as they are generally the first area to be sacrificed.

One policy maker from Saskatchewan expressed concern about independent organizations that have been traditionally thought of as being credible by the public having a vested interest, for example, the drug companies and universities conducting research together and suppressing the publication of negative results, as was the case of Sick Kids and the University of Toronto. In the opinion of the Saskatchewan policy maker:

> *I'm very concerned...about what's passed off as research related to pharmaceuticals. I mean there's a lot of very, very critical information that's suppressed by the pharmaceutical companies, the universities are compliant, colleges of pharmacy are compliant, colleges of pharmacology are compliant...It's a very, very unethical field.*

This observation raises a very real concern with the assumption that just because research is being undertaken at a university that it is automatically of good quality. The partnerships between universities and pharmaceutical companies to create new drugs and products have created some legitimate concerns about the agencies being able to separate effectively their responsibility to their public versus that to their shareholders. There have now been enough examples of the public trust being compromised that more open and explicit transparency of the agreements between the public and private bodies must be shared publicly so as to ensure that the public interest is not subverted for shareholder gain.

Summary

Policy makers identified many of the same sources of HQE – staff, agencies, and researchers – but added several more categories, like the Romanow Commission discussion papers, networking with knowledgeable people from the health research field, and having access to quality peer-reviewed literature. Poor sources of evidence were identified as the Fraser Institute, Parkland Institute, and that from advocacy or interest groups. This observation underlined the need for the development of clear criteria of what is to count as HQE. The drug or medical device industry that might be attempting to enthusiastically market its products was another source of LQE. On the question of autonomous production of HQE, policy makers felt that unquestionably the objectivity of the research should be unfettered by any kind of influence. The rigours of bringing objectivity to bear and to eliminate or reduce bias should be paramount. They did, however, make the suggestion that where there was a significant advantage to doing the research internal to government, this should be possible as long as researchers are not interfered with. Policy makers felt, like politicians, that there was a need to establish a greater independent capacity to more effectively create new knowledge in response to questions for which there was inadequate information.

Researcher

Sources of HQE

Alberta and Saskatchewan researchers identified the peer-reviewed literature as the most frequent source of HQE. This evidence is much more readily available today than was the case 20 years ago before the rise of the Internet. These can now be accessed in print form or much more conveniently from the Internet from sources like the Cochrane Collaboration, Bandoler, PubMed, University of York CRD Database, and CHSRF.

Sources of LQE

Researchers in both provinces identified organizations with a specific mandate, particularly those in certain camps that align themselves with particular interests as sources of LQE. A Saskatchewan researcher identified *"personal opinions, historical practices, the views of groups unsubstantiated by data, sloppily done studies, very small studies that are not transparent."* One way of assessing the validity of the evidence would be to scrutinize the peer review process that it had undergone. The Fraser Institute was identified as a source of poor evidence; other poor sources were government, consultant reports that were not transparent or externally reviewed, opinion pieces, and testimonials from individuals with a vested interest. One of the qualifications to testimonials was the usefulness of the *N* of one; a case study conforming to rigorous methods to inform a specific question was, however, a useful form of evidence. A Saskatchewan researcher pointed out the vice and virtue of the anecdote:

> *...probably the most influential suspect source of evidence is the anecdote... the personal story that is often highly influential. And I'm not saying it isn't evidence and I'm not saying it may not be valid evidence but it is certainly, despite its compelling nature and its ability to resonate with people, it can be too influential. If it - a good anecdote will illustrate a broader phenomenon. So an anecdote or a story that essentially mirrors the results of an RCT is great. It actually brings it home to people and makes it alive. It is an outlier anecdote or a personal view where there is no connection to any science and there is no connectable way to link the two, then it can actually lead you in the wrong direction. It can lead you to bad decisions. This is where politicians and some senior policy makers often fall prey to a heart-rending tale and it's even the case judicially frankly.*

This observation underlines the need for policy makers to be prepared to challenge the anecdote or opinion as a form of HQE. A second Saskatchewan researcher also referred to anecdote:

> *There's a lot of anecdote out there. I think, actually, I used to use the phrase that there's too many MBA's in health care ... and, when I said that I would expand on that by saying there's too many Managers By Anecdote. I think that is one of the greatest barriers that we have to change at the moment ... is the anecdote.*

The message from these observations is that anecdotes can be based on HQE or poorly formed opinions. Just as with research evidence, mechanisms for separating the good from bad anecdote will be necessary.

Researchers cautioned that evidence should be looked at critically to ensure that an appropriate method was used to answer the question asked. This quotation captures the sentiment of how qualitative research methods can be used to answer questions that only lend themselves to a qualitative approach:

> *...there have been fairly significant strides made in the last 10-15 years around making qualitative research more systematic in nature. And there have also been some variety of tools that have started to come out of that...But, and if you think about what politics is about, politics has got a lot to do with perception and some people would say that in politics perception is reality. So if you're doing qualitative research on something that is inherently political in nature and you're looking at the perceptions of the different stakeholders and you're doing it systematically and in the end you're going to have a clear sense...of what the different perceptions are and what that tells us about the political process...it's more a matter of having a methodology that's appropriate to whatever phenomenon it is that you're observing.*

Production of HQE

Researchers from both provinces felt that independence was essential in the execution of the research but that there needed to be a connection with policy makers to ensure relevance. Maintaining independence was also important for the sake of providing credibility to the research in that it would more likely be accepted as independent if it were conducted in an arm's-length agency. This also provides a check that there will not be undue influence from politicians. However, it was also pointed out that there should be a role for funders to help set the agenda. A Saskatchewan researcher stated:

> *Yes, in the execution of the research but I'm all in favor of at least some research being linked to an agenda that is jointly developed by policy makers... You create the demand side from conception and you create a sense of ownership over the anticipated findings in decision makers and I hope it would energize the researchers a little bit to know that there is a market out there for what they do and help them to walk a kilometer or*

> *two in the decision makers' shoes in the process of doing the research to ensure that it's not just sound methodologically but it's also relevant in that it covers enough ground to deal with the issues that the decision makers will have to deal with.*

The advice underscores the point that there needs to be the establishment of a firewall to protect the objectivity of the creators of evidence from the evaluators of it. However, a closer linkage for the sake of relevance would help facilitate the uptake of the research findings. One problem identified with too close a link is the concern of getting caught up in working on projects that are the flavour of the month. An Alberta researcher describes this dilemma:

> *...I think the fact that they're so god damned arms length right is one of the problems...I mean, so the intellectual expertise inside government has been declining rapidly, ok, and one might argue whether it has or hasn't been increasing in universities. But the gulfs getting wider. We don't have enough people to walk both sides of the fence. We don't even have enough to have a reasonable amount of respect on the academic side that can get around a board table in a policy-making sense and influence. They're not there. Now, do you have to have a firewall? Well, you always got to have a firewall to help create objectivity between the creators and designers of something and the evaluators of something. That's common sense, ok? Does that mean that policy-makers and researchers should stay apart? No, absolutely not...I think that they should cohabitate... But to me, co-hosting and interacting stronger public policy figures and evidence production would ...result in better evidence production that was more apt and more uptake on other side.*

One Alberta researcher did express an opinion that there appears to be a gradual shift and erosion of independent research being done. In his words:

> *It seems to me that just in a general sense that academic researchers are getting increasingly pulled in to political decision making and are becoming almost, increasingly becoming slaves of political decision making. Which in one sense is good for people such as myself because I've been doing applied research for a long time...The downside is that the funding bodies themselves seem to be relying too heavily on policy decision makers to provide them with direction as to what their priorities should be. So the result is that one year they'll do a survey of the decision makers and they'll get one list of priorities. And by the next time they do the survey, the list will have changed, so it's kind of a flavour of the month thing which everybody in government knows happens all the time. And the*

> *result of that for academic researchers is that while you might apply for funding with a granting agency in one round and maybe not be successful, if you were to go back in the next round you might find you could no longer apply for that particular project because the funding agency priorities would have changed based on the feedback you got from decision makers. So I think there's a danger that the ability to do independent research is going to slowly erode, be slowly eroded this is kind of a creeping shift that's happening but you can definitely see it.*

This concern illustrates the balance that will be necessary to achieve in providing researchers an opportunity to conduct curiosity-driven research on the one hand, and applied research, which is seeking to answer a specific health policy issue, on the other. The answer would seem to be to provide a wide variety of research opportunities and to build the capacity in the province to be able to respond to the broad spectrum of research opportunities that arise.

Summary

Researchers emphasized the peer-reviewed published literature, particularly that which is available in electronic form on the Internet, as a ready source of HQE. Poor-quality evidence was identified by researchers as originating from organizations that had interests that they were wishing to promulgate; this included interests groups, think tanks, consultant reports, and government reports. Researchers were in favour of research being conducted in as objective an environment as possible but insisted that linkages with policy makers and politicians to maintain relevance and timeliness were essential. The mechanisms and processes to be established to mitigate these challenges will be the subject of the model for policy making arising from this study.

Citizen elites

Sources of HQE

Citizen respondents identified the same list of good and poor sources and added policy analysts, individuals in practice who were authorities on the subject, as good sources. One citizen suggested the need to approach both the traditional authorities on a subject as well as the mavericks that were pushing the envelope on some of the issues in order to get a balanced view. Other sources of good evidence identified were hotlines and opinion leaders. These of course would need to be assessed to determine the veracity of their information.

Sources of LQE

Citizens in both provinces identified several sources of poor evidence; however, the most common one mentioned were sources driven by a commercial interest. Drug companies, medical device companies, and the entrepreneurial sector were identified as sources that might exaggerate their claims in order to gain a market advantage. An Alberta citizen offered the following observation:

> *...the people or entities that have large axes to grind, one has to be very careful with. So some manufacturers of some pharmaceuticals ...one has to be very, very careful that the tests and research and the evidence is very objective and appears so and that the decisions made in the processes are very transparent.*

The second most common source of poor evidence identified was expert advice or opinion based on anecdote from a small number of people or patients. Other sources were opinion leaders without supporting data or the simple acceptance of their authoritative advice without checking their credentials. One informant pointed out that sometimes authority figures will speak outside of their area of expertise and, by virtue of their position, their advice is assumed to be valid. An Alberta citizen elite observed:

> *The higher you, the more privileged you are authority I think there's a much higher obligation to be very careful what you say ...For example, if a dean says something at a meeting of a bunch of doctors and he puts out a statement and I would put out a statement, there's a higher probability*

> *that they'll think that his statement is correct because it's more than likely based on fact, he should know he's in the scientific field. And I think there's a real higher onus on people who are in positions of authority to be really clear because you can start swaying people.*

Another informant pointed out those anecdotes could be good evidence; however, there is a need to be able to separate the fallacy from fact. Other sources identified were non-peer-reviewed journals, the Fraser Institute, and the Internet unless it has been credentialed as a high-quality source. A Saskatchewan citizen offered the following critique of the Fraser Institute:

> *...look at that wait list survey. They phoned up physicians who have got something to gripe about the system. And say, what do you think your wait times are and what are they ...that's not empirical research. That is ideology driven dribble. It's outrageous. Now, the Fraser Institute and whoever's funding them can waste their money any way they want. What really bothers me is for the Globe and Mail, a so-called reputable media, quoting them.*

One informant pointed out that frequently an advocacy group would use the media or press to put forward a certain point of view in an effort to manipulate the opinion of the public. The veracity of this evidence must be challenged.

Production of HQE

The citizens in the two provinces were in agreement on many points in respect to the production of credible evidence. They felt that a separation of doing the research independent of outside influence was important; however, there needed to be a bridge between the researcher and policy maker on ensuring that the policy question is relevant and the implementation well facilitated. The important characteristic identified for the research process was that it would be open and transparent to the public and all stakeholders. An Alberta citizen stated:

> *I don't think there should be an arms length relationship but I think it depends on how you define that. In other words I don't think you can have the decision makers in the pocket of those who are providing evidence or promoting some particular service or product but I think that it has to be an objective understanding by the policy makers that they're going to get some information that they may not like and they're going to get different*

> *opinions which they, as policy makers have to make a determination about....I think it would be not right to have them in totally separate, water-tight compartments ...as long as the process is transparent, I think that each should know what the other is doing and the problems facing the other policy makers and the others who are doing the evidential work.*

The principles of transparency, openness, and being explicit of what work is being conducted and how it is being done is a useful remedy for balancing the requirement for autonomy on the one hand, but being relevant and timely on the other.

This opinion was mirrored by a Saskatchewan citizen elite who felt that good research could be conducted in a government shop, but it needed to be open and transparent in order that the public and stakeholders could see how it was conducted. In his words, *"It's about scientific rigor and it's about the ethics of the organization."* An Alberta citizen suggested that the question of autonomy was not as important as having clear guidelines of how the relationship is defined so as to always preserve the scientific freedom and integrity of the researcher. This advice will help shape the development of a model for increasing the effective use of HQE in health care policy making.

Summary

Citizens added authoritative hotlines, policy analysts, those in practice (traditional and unorthodox), and opinion leaders (with qualifications) as sources of HQE. Citizens identified many of the same sources of poor-quality evidence but included sources like commercial interests marketing their products, expert opinion based on a small sample, voices of authority speaking outside their area of expertise, and media coverage of an issue that has been influenced by an advocacy group to portray a certain point of view to the public. Citizens were generally in agreement that there needed to be distance between policy makers and the researcher; however, there needed to be linkages to ensure that the right question was being asked, the appropriate method was being used, the results were timely, and the researchers would be involved in the implementation of the findings. Finally, they felt that research could be carried out in any domain as long as independence was protected and the processes of the research were open and transparent to the public.

Conclusions

Table 23 identifies the sources of HQE and LQE from the perspectives of the four epistemic communities in Alberta and Saskatchewan. Politicians tend to identify HQE sources institutionally, while researchers do so by international standards of best practice. Politicians rely on the reputation of the institution to assess the quality of the evidence, while researchers rely on the standard of best practice within that discipline. Politicians identified public polling as an important form of evidence, which was not shared by others. Policy makers and citizens appear to have the broadest range of sources and identify reputation as an important criterion. All of the epistemic communities identify a challenge function as being important to test all evidence against. All shared a concern with bias and vested interest being advocated in the form of HQE.

Table 23: Summary of Sources of HQE and LQE by Informant and Province

<table>
<tr><th rowspan="2">INFORMANT</th><th colspan="2">WHAT ARE SOURCES OF HQE?</th><th colspan="2">WHAT ARE SOURCES OF LQE?</th></tr>
<tr><th>Alberta</th><th>Saskatchewan</th><th>Alberta</th><th>Saskatchewan</th></tr>
<tr><td rowspan="3">Politician</td><td colspan="2">Department of Health
Universities
Health Research Agencies
NGOs</td><td colspan="2">Advocacy groups
Opposition members</td></tr>
<tr><td rowspan="2">Opinion polls</td><td>Symposium</td><td>Poor polling</td><td>Unions</td></tr>
<tr><td>Forum</td><td>Not contextual</td><td>Professional associations</td></tr>
<tr><td rowspan="7">Policy maker</td><td colspan="2" rowspan="7">Department of Health
University researchers
Peer-reviewed publications
Health research agencies
Commissions
Networking</td><td colspan="2">Fraser Institute</td></tr>
<tr><td>Parkland Institute</td><td>Vested interests</td></tr>
<tr><td colspan="2">Media and Newspapers</td></tr>
<tr><td colspan="2">Advocacy groups</td></tr>
<tr><td>Data without context</td><td>Vested interests</td></tr>
<tr><td colspan="2">Internet</td></tr>
<tr><td colspan="2">Suppressed negative clinical results data, e.g., U of T</td></tr>
<tr><td>Researcher</td><td colspan="2">Peer-reviewed literature</td><td colspan="2">Vested interests
Fraser Institute
Government
Consultants reports
Opinion pieces
Testimonials – unless a good case study</td></tr>
<tr><td>Citizen Elite</td><td colspan="2">Policy analysts
Opinion leaders
Hotlines
Mavericks and traditionalists</td><td colspan="2">Commercial interests, drug companies, medical device companies
Expert advice or opinion
Opinion leaders without data or credentials
Non peer-reviewed journals
Fraser Institute
Internet – unless credentialed
Media and press</td></tr>
</table>

Note. HQE = high-quality evidence; LQE = low-quality evidence; NGOs = nongovernmental organizations.

Table 24 identifies and summarizes how the epistemic communities viewed how HQE should be produced – a blend of having some capacity in a department of health to it being supplemented by external sources for projects that require independence was a common view among all epistemic communities. There was, however, a caution that a connection is necessary for relevance and timeliness to be maintained, along with objectivity and the process being open, explicit, and transparent to the public. Policy makers were more likely to suggest that evidence creation and synthesis should be conducted externally but with an embedded linkage to the setting being studied. All communities felt that a blend of internal and external evidence creation was ideal, with a sensitivity being used to weigh the benefit and risk associated with one approach versus the other.

Table 24: Summary of How HQE Should Be Produced by Informant and Province

INFORMANT	HOW SHOULD HQE BE PRODUCED?	
	Alberta	Saskatchewan
Politician	*Internally and externally – depending on timing and need for perceived independence*	
	With consequences of implementation with researcher involvement	Independently but with interdependence to avoid silos
Policy maker	Externally except where that option is not available	
Researcher	Independently to maintain objectivity but connected for purposes of relevance and timeliness	
Citizen Elite	Preserve independence but ensure link for relevance Open, explicit, and transparent	

Chapter Ten

Values, opinions, ideology, and HQE: Conflict and resolution

Introduction

The objective of this chapter is to interrogate whether and how the four epistemic communities discriminate between and among values, opinions, ideology, and HQE. This is an important issue because in the public policy-making environment, there are many ideas circulating in the form of evidence, values, opinions, and ideology, which are competing for attention, and positions of privilege to inform legislative, regulatory, and policy actions. Can members of the respective epistemic communities effectively differentiate among these ideas, particularly when they come into conflict? How does one choose to support a particular value over HQE in arriving at a decision? What criteria are used? Are the criteria explicit, open, and transparent? Is there an opportunity to enter into a discourse in the community surrounding the relative merit of each?

A secondary point of importance is whether and how the epistemic communities differentiate between what is good versus bad evidence, values, ideology, and opinions. What does a community hold as "good" values versus "bad" values? Can we tell the difference? If we can tell the difference, what criteria do we use? Does the same apply to whether ideology and opinions are informed or not? It has been demonstrated in the previous chapters that not all ideas are of equal merit or value; if that is the case, we need to be confident that, when it comes to health care policy making, we are able to clearly state what criteria will be used to judge whether policy actions are in the general population's interests or not.

A third component that this chapter attempts to shed light on is how the respective epistemic communities have come to see conflicts among values, opinions, ideology, and evidence resolved satisfactorily. What mechanisms have and have not worked? These observations and insights will provide the study with the means to help structure a model that will identify a way of mitigating these conflicts with a positive impact on population health. The sentiment in policy and research circles today is that ideology, values, or opinions can often trump HQE in the policy-making process. Each of the epistemic communities was asked to make a judgment as to whether they thought this was true and why.

The final part of this chapter examines the response of the informants to the question of whether they had any suggestions for improvements they would recommend for the health care policy process.

Politician

Does ideology trump HQE?

Alberta politicians generally felt that ideology played a greater role than evidence in impacting the course of action in their province than was expressed by the Saskatchewan politicians. One Alberta politician pointed out that ideology-trumping evidence was true in most facets of life and health care was no different. A second pointed out that the role of politicians was to put the balance into these opposing forces during the policy-making process. He felt that there was a growing sentiment in society to see the health care system as based on sound, rational, and best available evidence.

In response to the question of whether ideology trumps HQE in policy making, an Alberta politician stated:

> *I would disagree because I look at, for example, and there are some examples of differences between Saskatchewan and Alberta; but overall if you look throughout Canada, if you look at reports that have been done to evaluate the health care system...regardless of the political party in all those provinces –PQ as it then was, NDP, Liberal, Conservative...they've all come to the conclusion that our health care system is not sustainable and that there are changes that need to be made. So I think that there is, regardless of political persuasion, there's a growing desire to change the health care system on a basis that is sound, rational, and based on the best available evidence.*

The view of this politician is that, regardless of the ideological debates surrounding health care funding and delivery, the royal commissions and task forces come to similar conclusions – changes from the status quo are necessary. This politician was particularly concerned with the future sustainability of the health care delivery system and he viewed one of the ways of preserving it as being through decisions informed by HQE.

One former Minister recounted his experience of where he and his staff had garnered all the "high-quality evidence" for a course of action to be taken, but the professional health care associations convinced the caucus to do otherwise. This matter was concerned with deinsuring of the community physiotherapy services as a medical benefit to citizens. The professionals were able to convince the cabinet that this recommendation was based on spurious evidence and that even if it were true, there was no alternative service option available in rural Alberta. This experience underlines the importance of introducing a mechanism that would have permitted the debate to occur where the correct question was being addressed, with all of the evidence being debated and shared publicly with submissions requested from stakeholders. On further inquiry with the informant, it was clear that the wrong question had been asked surrounding this policy issue: Is community physiotherapy an effective form of health care intervention? The question in this form is seductively simple. A more instructive phrasing of the policy question would be to ask: What evidence exists to support the use of community physiotherapy for what specific clinical conditions, with what specific forms of intervention, and with what specific population or subpopulation? What outcomes would be considered to signify success and against what standard of alternative care is community physiotherapy being compared? Finally, an Alberta politician pointed out that evidence may very well be of the highest quality, but the timing for its consideration may not be favourable for its adoption.

None of the Saskatchewan politicians agreed with the statement that ideology might trump HQE. The Saskatchewan politicians were of the view that ideology may cause a delay in the policy until you were able to bring an adequate number of people along but that, ultimately, evidence does win. A Saskatchewan politician stated:

> *...there is delay of policy because you have to bring people along – you can't, again, dictate to them the way it is going to be. I think, ultimately, the evidence wins... you make these changes, you pay a huge political price for it, but ultimately...the policy makers inform the politicians and they inform part of the knowledgeable community, which accepts it, and*

> *ultimately you get enough people that are going to go along, even though it may not be ... if you had a poll about it, a lot of people may not like it.*

This observation underscores the importance of a society being prepared to support the education of its citizens to be knowledgeable and responsible consumers of information.

A Saskatchewan politician pointed out that a fundamental contested area of ideological debate with HQE was whether health care was a market commodity or a public good. The politician stated that:

> *...the Romanow Commission tried to take an evidence-based approach and ended up supporting a particular set of values and ideology, but I think that is appropriate. Knowing Mr. Romanow, as well as I do, I think that there is no doubt that he has certain values and ideology about health care himself. But ...he will start out with the evidence and if there is empirical evidence that says," well, actually, this system is totally inefficient and, actually, if you had private hospitals the waiting lists ... it would be cheaper and the waiting lists would be almost only half as long" ... Mr. Romanow is the type of person that would look at that, get advice, and say, "as difficult as it is, that's the way it is."*

This politician captured very accurately the essence of the debate between public versus privately delivered health care. It may be that a politician has certain ideological perspectives but when evidence arises that shakes the veracity of cherished views, the individuals need to seriously reconsider their viewpoint.

Another Saskatchewan politician commented that in politics there are frequently times when one must put the broader good before that of vested interests, and, as a government, one needs to be prepared to "take its lumps" for doing the unpopular thing:

> *In my experience, there have been occasions where you just simply have to say, "No," to a vested interest group. "The evidence shows another way" and if it means a strike as it did in my case in 1999 with the nurses...hugely, hugely disruptive to the health care system first and foremost, hugely damaging to the government of the day...hugely damaging as the subsequent election showed ...you just have to make that decision and if the public decides otherwise, they decide otherwise.*

The conviction of this politician in acting in accordance with what was believed to be the best evidence in spite of the consequences is a characteristic not often publicly acknowledged in politicians. During the interviews with the politicians from Alberta and Saskatchewan, in the majority of cases where there was a contest between ideology and evidence, the politicians frequently felt unsupported with the quality of evidence that demonstrated a certain course of action. The evidence was often not well documented, contextualized, and/or clearly communicated. This weakness points to the need for an improved public service to ensure that the evidence being prepared for politicians has had adequate time and resources assigned to it so that it provides as solid a foundation for policy making as possible.

The politician went on to say that one way of defraying the public issue was to have an external validator, an outside agency that would adjudicate on whether a policy effort was supported by evidence or not. Finally, a Saskatchewan politician observed that the government could have closed or converted the 52 hospitals in Tory ridings but decided against that – the conversion was based on a set of criteria from good evidence developed by the Department of Health. The same politician made an uncharacteristically "nonpolitical" statement: "*The right thing to do is always the most political thing to do.*"

Defining and differentiating among HQE, ideology, values, and opinions

The point of the question differentiating between and among ideology, opinions, values, and HQE was to ascertain to what degree the informants appreciated the distinctions when it came to dealing with information and data in the health-policy-making arena. How do we propose to introduce values, opinions, and ideology into the equation for health care policy making? We will start by defining the terms. Ideology is defined by Jary and Jary (2000) as "any system of ideas underlying and informing social and political action…more particularly, any system of ideas which justifies or legitimates the subordination of one group by another" (Jary et al., 2000, p. 286). Blackburn (1996) says of ideology, "Any wide-ranging system of beliefs, ways of thought, and categories that provide the foundation of programmes of political and social action: an ideology is a conceptual scheme with a practical application" (Blackburn 1996, p. 185). Jary and Jary, as well as Blackburn, recognize that ideology can be an instrument for social or political action, but it is Jary and Jary that highlight the point that it can be an action that leads to domination of one group over another.

Values are defined by Jary and Jary (2000) as "ethical ideals and beliefs. The term is often used to distinguish scientific knowledge from 'values', especially where such 'ethical' ideals, 'oughts', etc. are held not to be, or as inherently incapable of ever being, 'scientific'…the central beliefs and purposes of an individual or society" (Jary and Jary 2000, p. 664). Blackburn (1996) says of value:

> To acknowledge some feature of things as a value is to take it into account in decision-making, or in other words to be inclined to advance it as a consideration in influencing choice in guiding oneself and others. Those who see values as "subjective" think of this in terms of a personal stance, occupied as a kind of choice, and immune to rational argument (although often, and curiously, deserving some kind of reverence, and respect). Those who think of values as objective supposesthat for some reason – requirements of rationality, human nature, God, or other authority – choice can be guided and corrected from some independent standpoint. (Blackburn 1996, p. 390)

Lay understanding of opinion can be garnered from *The Concise Oxford Dictionary* as "judgment or belief based on grounds short of proof, provisional conviction, view held as probable" (Sykes 1987, p. 715). I am not using the word *opinion* in the context of expert opinion, although this does not preclude that "expert opinion" may be subsumed under our sense of using it. Opinion is used in this study to capture the ideas that are in circulation in the community. They may be based on good or poor evidence and they are shared among citizens as their perspective, belief, or attitude on a topic without getting into the detail or background of how they arrive at that opinion.

An Alberta Minister used the example of contracting out health care services to the private sector by a health region as something that was ideologically different between Alberta and Saskatchewan. Both provinces value a high-quality publicly funded health care system; in other words, their ends are the same, but their means of achieving this may be different. The idea of a publicly funded and accessible health care system may be a value and/or an ideology. The idea that services in the health system could be delivered by the marketplace was an ideological point that may not come into contradiction with the value of a publicly funded and accessible health care system. The ends are based on values or ideology and cannot be derived scientifically, although they can be scientifically and systematically documented. On the other hand, the means of how best to achieve the ends, a publicly funded health care system with universal access, can be supported with HQE. An Alberta politician stated:

> *The Alberta provincial government agrees with the Saskatchewan provincial government that we need a high quality, publicly funded health care system. That's something they would share in common. Now how you would go about achieving that, we may have some different answers. So in Alberta we would not object to a privately owned facility that did hip operations under contract to a Regional Health Authority. In Saskatchewan I think they probably would... In Saskatchewan, philosophically, ideologically they are more of the view that it's important if the public, a public service be provided by a publicly owned building – we don't think that. So there are ideological differences even though the end goal is still the same.*

From my perspective, the debate centres on what costs are taken into account by the two ideologies. In the narrow sense, a conservative government may chose a narrow definition that would account only for direct government expenditures and not account for the social costs associated with the exclusion to health services, which would be borne by the individual needing health care. A socialist government would, on the other hand, enter the costs of universal access to health care as something balanced off by the benefits accrued by individuals.

One of the Alberta politicians described a structured and deliberate process (identifying the values and ranking them in respect to an explicit criteria applied against the values) to determine what the relative weight of the evidence and values around an issue would be. This could be used to inform a policy decision that would reconcile HQE and values or ideology. Saskatchewan politicians had a similar perspective; they also differentiate between HQE, which they consider to be the facts, and the ideology and values as being more personal. One did say that in the interplay between facts and values, if facts arose that challenged those values, one would need to be prepared to change - unless one were simply dogmatic and prepared to live with a contradiction of facts and values. Another Saskatchewan politician identified the mechanism of deliberative choice, which he felt was an excellent way of attempting to bring the values of citizens forward and integrate them into the policy-planning framework in a meaningful way. One other Saskatchewan Minister described the need to interrogate the evidence or the person presenting it to get an appreciation of how much is fact and how much values. This individual also described the use of pilot projects as one way to test a project in which there is some debate as to the veracity of the truth claimed about it. Overall, politicians, with one exception, did not have an explicit framework or criteria on which they would rely to help sort out what were the good-quality versus bad-quality evidence, values, ideology, and opinions relative to the public health interest surrounding a position.

Successful means of reconciling conflict

Politicians were asked to identify successful ways they had seen conflict between positions of ideology or values and HQE resolved. A wide variety of experiences and insights were shared in response to this question. One Alberta politician recounted that if the conflict were between the government and one of the health care professions, such as the nurses or doctors, and they were split over an ideological issue, then the public was more than likely to side with the health professions, which means the government usually has to work very hard to get the public onside. An Alberta politician pointed out:

> *The problem is that you can't win a battle with nurses or doctors in this province, or any other one, because they have far too much public support, far too much access to the public, and so what you do with nurses and doctors and other health care professionals is that you have to try very hard to get them on your side ... you have to ... they have to be part of the solution.*

If issues in conflict do not get resolved at a basic level of bureaucratic functioning, then they have to be resolved with a higher political authority and if that is called into play, then other factors besides HQE begin to enter into the equation. This sets the stage or an incentive for issues not to be resolved at the level where HQE is likely to be the most prominent in informing discussions. If the aggrieved party wishes to prolong the negotiations until such time as it is referred up to the political level, if the aggrieved party feels that its lot can be improved by influencing public sentiment, then it will try to do so in an effort to achieve a more favourable settlement with political influence than would have been the case in the previous situation in which HQE predominates. If they have misjudged their ability to raise public support, they may find that at the political level they need to "trim their sails" and the consequences of encouraging political adjudication of their issue backfires on them.

Several of the narrative histories, the Mazankowski Report, for example, reviewed earlier identified one of the strong drivers of health care policy in the last decade as being an attempt to contain increasing rates of expenditure in the health care system. As long as the fiscal imperative was strong, it encouraged a greater reliance on HQE to inform the most prudent expenditures. Once the fiscal pressure is off, it is less likely that the government can force a decision that will be against the self-interest of a health care professional group. Politicians are not likely to have a great appetite for doing things that are unpopular when there is not the fiscal pressure to maintain a tight fiscal imperative. One of the Alberta politicians mentioned the debate over the public versus private facilities to deliver services to the public as an example where the issue became a media event because of the ideological battle that arose because of the contrary positions articulated by the government and the interest group, Friends of Medicare.

Saskatchewan politicians felt that successful processes for resolving the issues required that each of the respective parties stay committed to their respective efforts – researchers to produce the research findings, policy makers to provide the facts with their opinions as to what range of options exist, and politicians to work out practical solutions. One Saskatchewan politician spoke about the fact that open and transparent debate is one of the most satisfactory ways to resolve competing views. He does not necessarily seek conflict for its own sake but sees it as a healthy way of bringing the public into the debate.

> *I generally don't favor conflict as a vehicle, strange as it may seem, to the development of public policy but I don't think it should be automatically dismissed in every case. It's the old thesis antithesis equals synthesis approach. A good healthy debate about the nature of specific reform in health care is acceptable, even if it's a conflict, because eventually it gets resolved and we know if the rough edges of each policy is knocked off, and*

> *the good is accepted and we move forward that way. Very Hegelian in its approach but nonetheless I think it can be done.*

Finally, one politician pointed out that sometimes the debate is with the evidence and the values and ideology may be in agreement. This often happens when the quality of evidence is very poor and politicians have no recourse but to proceed with the best accommodation of values and ideology.

Respective value of the actors

The politicians in both provinces appreciate that each of the actors brings considerable but distinctive expertise to the policy process. Most agree that it is best to work as a team collaboratively and that the politician, cabinet, and cabinet committees make the final decision by adjudicating among the competing ideas in circulation. It was also pointed out that their respective roles should not become blurred. If all members of the epistemic communities remain committed in their professional responsibility, the outcome is more likely to be fair and democratic. One of the mechanisms identified in Alberta as a useful avenue for open and explicit seeking of advice is the Standing Policy Committees, which have been established as a mechanism to provide citizens and stakeholders with an opportunity to make presentations to the politicians and bureaucrats.

Respective needs of the actors

On the question of whether the needs for HQE were different for different actors, all of the politicians agreed that the needs of the actors are different but they each need HQE in the form that is most useful for them. One Minister described the need for politicians to be able to separate the signal-to-noise ratio: there is lots of information out there, but only a small bit of it is useful for making the most appropriate decision.

> *There's a difference between signal and noise. Signal is what you want, noise is all the background chitter chatter or static or what have you. And in communicating we need to be able to separate signal from noise and the signal that is required by an elected person is quite different than the signal that is required by a researcher...the signals and the noise are quite different depending on the audiences and so research needs to be framed in a way that separates signal from noise so that the audience that*

> *you're trying to influence in fact gets what it is that they need and understand as opposed to all the rest of it.*

The observation that the message needs to be appropriate for the audience is key to improving the uptake of much of the HQE that is produced through the research enterprise. What relevance does it have for different audiences?

Improvements for the future

Politicians in Alberta felt that developing mechanisms to bring all the health care providers, general public, and government to have open discussions about policy would be helpful; the summits were a good example of how this was done in the past but they were not sustained. One politician stated:

> *I've thought a lot about this ... if you could get a process where you could bring the health care providers, service providers, to link up with the general public, both the well ones and the sick ones, and government, we haven't found the magic forum or means of doing that except as individual MLA's.*

They also felt that a mechanism should be introduced that would allow research to be certified or validated so that people were not wasting their time on low-quality research. An Alberta politician felt that

> *I would like to see a type of, a process that would certify and summarize research that's being done so that we don't spend our time looking at research that has dubious value and that is framed in a way that is understandable to policy makers.*

Another view was that evidence that is produced needs to have more certainty in it; if it does not, we should undertake the research projects that would help to reduce the uncertainty. It was noted earlier that the public policy applicability of certain types of research has limitations; for instance, research that points out that money can be saved by not keeping premature neonates alive who have a poor prognosis for life or to limit access to kidney dialysis machines over a certain age is simply not going to fly – so why do it? In another Alberta politician's words:

> *That is, every time you think health policy change, think about the vested interests – the people that work in the system – the public – and the politicians. You know, here's my suggested policy change with respect to low birth weight babies or people on dialysis and will all the people with vested interests – the mothers, the docs, the nurses, the politicians – approve? If, at the end of the day, the answer is "none of the above will approve," then start working on another project.*

Another politician suggested that researchers become more deliberate about organizing and prioritizing the health research agenda. A final observation by an Alberta politician was to consider developing education opportunities for MLAs on some of the tough issues facing society. This suggestion arose because of one Alberta politician's positive experience with such an opportunity. He states:

> *...take some people who have done some work at the university and have a one day seminar with elected MLAs, invite elected MLAs to the university and have some of the information presented to them, ...last week about 20 MLAs went to the university and we sat at the Telus Centre at the university and we listened to lectures from a number of different people and it was quite a good interaction. So those are the things that I'd like to see continue.*

Saskatchewan politicians felt that more resources should be allocated for research. One politician stated that

> *...there is always the need for more resources to be put into health research ... and if you put more money into it, then you'd have more high-quality research in different areas and you'd have more information on which to go on.*

They also felt that the establishment of the National Health Council would lead to a much more stable, standardized, and rational process of reforming the health care system in the future. The creation and application of research to inform policy was necessary but it was not going to be sufficient: a political will to cooperate and resolve problems jointly was essential. In the words of a Saskatchewan politician:

> *All we can hope to do is move closer to good evidence as the foundation for health policy ... to do that is to find areas of stability in governance and the federal provincial territorial cooperative role through the Health Council or some variation thereof, through stable funding, through transformative... and most importantly making sure that the Canadian public is privy to this.*

It was also felt that taking more time to explain issues to the public was important. In a Saskatchewan politician's words:

> *I would recommend that more time be taken to explain what you are doing … to one's colleagues in Cabinet, to other MLAs and to the public. The communications aspect of health reform was very difficult. The concepts were difficult to communicate in a ten second clip and it moved so quickly that some MLAs and the public did not fully understand the reasons for some of the changes. So, by informing people better, implementation would be easier… strategic communications, perhaps is the most important thing to the implementation of future health policy development. The other improvement would be to strengthen the relationship between policy maker, politician and researcher and the citizen. If we can get that relationship right, it will strengthen future health policy development.*

Summary

Being asked to differentiate between and among values, opinions, ideology, and HQE was one of the most challenging for informants but they all felt it was important to tell them apart. Alberta politicians agreed more frequently with the statement that ideology trumps HQE than was the case with Saskatchewan politicians who felt that HQE eventually wins out. Politicians felt it was important and necessary to identify and make explicit the values and HQE and their influence on policy making. This is, however, easier said than done. One of the respondents pointed out that values tended to drive the ends of public policy – for example, Alberta and Saskatchewan politicians support a high-quality publicly funded health care system – and this is an end. How to achieve that end, for example, contracting out to the private sector or doing it in the public sector, is a means. Disagreement on means occurs because Saskatchewan does not support contracting out (it is a value or ideology) and Alberta feels that it is appropriate and does not challenge the ends that they are agreed to. The differing perspectives may be due to the more communitarian political philosophy inherent in Saskatchewan politics and a more marketplace-oriented political philosophy in Alberta. One suggestion made by an informant to reconcile among the differing perspectives was to employ deliberative choice methods to systematically bring the value evidence to bear on policy questions.

Satisfactory resolution of issues between ideology, values, opinion, and HQE were identified by several of the politicians. One asked the question: Satisfactory for whom?, the point being that we ought to focus on the public interest. Alberta politicians saw that issues would often get pushed into the political level of decision making in an effort to mobilize public support for the group's position and then have the politicians give in on the issue. The danger in this is that if public opinion cannot be mobilized or is not successful, the consequences could be worse than the original position offered. Saskatchewan politicians felt that each of the epistemic communities has a responsibility to carry out their role and if they do it well, then the issues will get resolved satisfactorily.

One final mechanism that was identified was that of encouraging open public debate on the issues to encourage public involvement and get their buy-in to the solution. Politicians felt that all of the actors were important but that they needed to play their respective roles professionally and respectively. The Standing Policy Committee was identified as an example of successfully bringing citizens and stakeholders to the policy-making table by politicians but was identified as a threat to democratic action by the researchers. Pilot projects were identified as one way to test whether an innovative idea might work or not.

In respect to improvement for the future, all categories of actors in both provinces felt that significant improvements in the policy-making process were necessary. Politicians in both provinces identified the need for effective integration of public sentiment into the policy process as a priority. Alberta politicians identified the need for a "third party" to conduct a "quality assessment" of research, as well as suggesting that what research was produced needed to have more certainty associated with it. If certainty was not present, research should be conducted to provide it. Finally, it was noted by Alberta politicians that a lack of effective linkages between the policy environment and the research community led to some research not being utilized because the results of it may be unacceptable to the public. Saskatchewan politicians felt that more funding to support more health research was necessary. Overall, Saskatchewan politicians appeared to be more disposed toward the use of HQE to inform policy making than were Alberta politicians. Alberta politicians understood the value of research but felt that it had to be approached with a critical eye.

Policy maker

Does ideology trump HQE?

Policy makers offered three forms of response to the question, "Does ideology trump HQE in health care policy making?" One policy maker took exception to the way it was phrased, feeling that the question was too simple, loaded, and pejorative. Four thought it was partially true and one thought it was absolutely true. It was an Alberta policy maker who felt that ideology might very well trump evidence for good reason – and that politicians had to take other considerations into account besides the evidence. Rather than trump, one policy maker preferred the terms tradeoff or accommodation, which were more suitable descriptions of what really happens:

> *There was a trade off made or an accommodation but to say it trumped, I mean politicians have to look at other considerations. Regional issues, budgetary issues, electability.*

It was also an Alberta policy maker who felt that ideology does trump evidence and felt that professional vested interests play a role through their elaborate power structures to either maintain the status quo or improve their lot. The policy maker also pointed out that the professions look at the world through their filter: there are few taking the broader community view. The policy maker also commented that our education and training programs for the health professions do not train them to take this broader view but to be narrowly focused on their practice domain. An Alberta policy maker felt that often ideology assumes that the evidence is there to support the position of the evidence, so the two are complementary rather than opposed to one another. One respondent from Alberta felt the statement was partially true.

The three Saskatchewan policy makers felt that the statement was partially true, making observations such as if the interests were brought around the same table to deliberate, it was harder to ignore the evidence; the fiscal crunch in the province made it difficult to ignore the evidence; and vested interests can be a formidable force. One observed that in Saskatchewan the use of solid policy frameworks based on evidence is better than in many jurisdictions, but that having 80% of the GPs on fee for service was a continuing example of where ideology trumped evidence:

> *We still have 80% of physicians on fee for service...there's a pretty strong evidence base that for primary care physicians, which are basically most of our...GPs ...That's not an appropriate payment. So that's clearly an ... instance where evidence is being trumped.*

Finally, one policy maker observed that it is the craft of policy making to get ideology, vested interests, and HQE to work together in the best public interest.

Differentiating among HQE, ideology, values, and opinions

Policy makers were asked to ascertain to what degree they appreciated the distinction among ideology, opinions, values and HQE when it came to dealing with information and data in the health-policy-making arena. All of the policy makers said they could differentiate among ideology, opinion, values, and HQE, but they did not have an explicit instrument or mechanism that they could point to for help in making this distinction. The responses ranged from an Alberta policy maker identifying gut feeling as a way to differentiate among values and between "good" and "bad" ideology, opinions, values, and HQE, which come from the heart, to belief in the market as being arbiter or believing that the downtrodden should be helped. Opinion is very individual and evidence is an empirical fact based on data. One policy maker pointed out that people's opinions might be wrong but not their values – values were something to be respected. Saskatchewan policy makers also indicated that differentiating among these was an implicit process. It was also pointed out that it was easier to distinguish among these in an experiment or in a trial, but much more difficult with macro health policy issues. One policy maker made the observation that sometimes calling someone or something ideological is an attempt to discredit him or her. The policy maker recounted the story of being approached by an individual and asked whether they thought a specific individual was "ideological"? The policy maker's response was "no," that the person was supportive of a publicly supported health care system that was based on sound evidence. In the words of the policy maker:

> *What I find interesting is that there's sometimes a thought that... if it comes to a certain conclusion, then it must be based on ideology. Someone asked me this question actually in the last week and they were doing a reference check on someone and they said, "Do you find this person to be ideological?" and I said, ... I find this person to be supportive of a public health system ... "I believe that conclusion has been reached on the basis of the evidence."*

What is supported by evidence and what is ideology is a contested subject in health care; for example, the same policy maker pointed out that British Columbia is currently introducing the contracting out of health care services on the basis of evidence that it will reduce costs – and Saskatchewan will not introduce these changes on the basis of ideology. Which is right? One interesting observation is that everybody wants to cloak his or her ideology in evidence. So how do we make that transparent? The policy maker also was not sure that people actually want this transparency – particularly if they have something to lose – power, money, or control. One other observation that was made suggested that it was necessary to interrogate an issue and to explicitly ask questions about the efficiency and effectiveness as well as the values and the ideological question.

Successful means of resolving conflicts

On the question of successful strategies for resolving conflict among ideology, values, opinion, and HQE, one Alberta policy maker observed that health care was the most political portfolio they had ever held – issues were emotionally charged and the media fanned the conflict around issues. Several policy makers in Alberta raised the circumstances around Bill 11 that was proposed to prevent private health care from encroaching into Alberta. The furor surrounding Bill 11 resulted in the senior executive staff at Alberta Health and Wellness being terminated from their positions for what was perceived by some as an inability to reconcile a request from politicians for certain forms of evidence. One of the policy makers described it as the politicians feeling with Bill 11 that there must be some evidence out there that was not being shared.

> *...I will bet you that in the minds of decision makers in government, the evidence was not credible. That it wasn't just the ideology was more powerful than evidence, but the ideology and values and opinion and everything behind the ideology led them to discount the evidence. That*

> *surely there was some other evidence out there that those retched NDP based treacherous academics and department bureaucrats aren't giving us, you know. Now of course they weren't treacherous, wretched NDP based academics and bureaucrats in the first place. But the government had a tendency, this is a strangely anti-intellectual government for a group that comes from the Lougheed tradition and has been so well in to finance things like AHFMR. But it's oddly anti-intellectual.*

Another policy maker felt that Bill 11 was one of the most misunderstood pieces of legislation; it was introduced as an attempt to prevent private hospitals from being opened in Alberta. However, the Friends of Medicare and the media turned it into a battle between private and public health care. The policy maker stated:

> *There was no way to get a rational reasoned discussion. Emotions on the front edge, right away and ... the media in their underlying interest to create conflict, play on those things. We were leading into a federal election. We had the Health Minister of the day playing games, Mr. Rock. ...he knew from Day One that what the Klein government was trying to do was not inconsistent with the Canada Health Act, but he would never say that. He would say things in a way to rouse the population and encourage their suspicions of the government. I mean it was a very unfair time. You had the medical profession who ... wasn't sure whether contracting out was the right thing to do but didn't think it was a big issue for them to get involved in and then when they decided to get involved because they wanted to use it as a lever in their negotiations. So it's a very politicized arena ... it's politicized because health care is important to people.*

The policy maker also added that, in their experience, they had never seen a politician reject HQE – they might take other things into account, but it was never rejected. Another observation by a policy maker was that everyone tries to leverage an issue to their advantage – it could go as far as holding up elements of health reform unless negotiations on the master agreement are finalized to their satisfaction. One final strategy identified by an Alberta policy maker was to postpone or not make a decision in order to resolve a conflict.

Saskatchewan policy makers spoke to two challenges of trying to resolve the tension between the HQE and ideology. The first was a policy of the government to permit the citizens in the health regions to draw the boundaries for their future regional health districts. This was a laudable approach, but it resulted in an extremely confusing set of boundaries drawn for the health regions:

> *So, they did this crazy thing and they created this totally, totally ridiculous looking thing, and there are other little municipalities that didn't like the municipality to the east of them so they joined something to the west. See this one sticking down here. And there were 45 and we nearly croaked. We had always envisioned about 30. But, this is what they did and then, you know, the boards were all created. But this was done by citizen activists.*

The other challenge was the daunting challenge of closing or converting 52 hospitals in rural Saskatchewan, one of the greatest challenges in health care reform. The fiscal imperative made it necessary even though the communities did not embrace it. Some of the suggestions identified for a successful resolution were to bring the evidence forward and explicitly look at how it impacted on the values, interests, or ideology of a certain group. This required all the parties to be open, transparent, and consistent in the application of rules that were agreed to. The example was given that if you made an exception with one MLA to get him or her out of a difficult issue with his community, you open up the issue with another 51 hospitals that were also facing closure or conversion to a health care centre. The lesson from Saskatchewan's experience with these two major issues was to trust that the open and democratic process of implementing policy that was very unpopular would in the end result in what was best for the society. In this case the evidence won out.

Respective value of the actors

On the whole, policy makers in Alberta and Saskatchewan perceived the value of the players to be equal and consistent with making the greater enterprise of health care delivery function effectively. Each had their role to fulfill. Saskatchewan policy makers did point out that strong leadership and knowledge on the part of the Minister and Deputy Minister is very effective in advancing the health reform agenda. All of the policy makers in Saskatchewan talked about the leadership provided by one Minister who worked very well with the Deputy Minister. The policy makers all respected the fact that the Minister would spend time on the front lines with the staff and not hide behind them.

One policy maker did make the observation that researchers' and policy makers' effectiveness would be greatly increased if they were more closely connected. Other observations were that if researchers did not look down at the political process, they would be of much greater help. It was also pointed out that researchers tended to be somewhat naive about politics and that the cultures of researchers and policy makers were so different that it is hard to believe that they can be part of the same world. There was a strong sense that there needed to be more common sharing of language and projects between the two.

Respective needs of actors

On the question of the needs of the actors, all policy makers were of the view that the needs of the four actors were different because they had different objectives and roles, even though overall they were working toward a similar end. Reasons given for them having different needs were the following: They are at different levels of understanding on an issue and they need differing amounts and details of information to make a decision. One policy maker was critical of the researchers as often not having the experience of making decisions and taking account of the stakeholder community. One policy maker saw their respective needs as cascading, starting from the researcher who needs raw data, which provides the policy maker with the information to give policy synthesis advice to the politicians. Each is trying to persuade the group above them. One policy maker pointed out that an informed decision is not the same as an evidence-based decision. A politician may very well take into account all of the evidence but may choose to give greater weight to other factors in addition to HQE. This raises the very real question of why the context of the other factors would not have been drawn into the evidence in a consistent and systematic way.

Improvements for the future

Policy makers from both provinces suggested increasing the capacity of the universities to respond to calls for research on policy questions. A policy maker from Saskatchewan felt that:

> *...I think the creation of more knowledge ...health...services research is hugely important. I think policy-makers are challenged by the degree to which we see the research emphasis being on the biomedical as opposed to the health services research... all the incentives it seems to me ...tends to be on ... drug research, more clinical research and it doesn't seem as sexy somehow to be the person whose researching whether it works or not ...*

An Alberta policy maker mirrored this view by stating:

> *...I guess, first I'd like to see our local universities invest more in faculty who could actually do health calls and research as opposed to what I call medical policy kind of research. I also think we need the, you know the old saying, "More light and less heat."*

Having the Minister and Deputy Minister provide leadership and supporting a climate for using HQE to inform policy making was identified as sending an important signal as to the importance of HQE. An Alberta policy maker identified the following opportunities:

> *...it is really about bringing these different parties together...Part of the solution is to do the groundwork in advance. It is about relationships, it's about shared learning, it's about getting the parties together. And understanding one another's roles. I've seen lots of researchers do themselves damage when they appear to have no interest in trying to understand that other world that they want to influence.*

Creating the appropriate incentives that would reward the use of HQE in policy making was identified as an important improvement. Helping create linkages among the players and ensuring that the questions being researched were relevant and researchable was important. Policy makers suggested that if researchers were involved in developing a consultation process for their research with relevant stakeholders, followed by a communication plan and an implementation strategy, that would make their research more likely to be useful. This would provide researchers with an opportunity to follow their research projects from inception to implementation.

Summary

Policy maker responses to questions ranged from a concern that the question of ideology trumping HQE was loaded and not a representation of how things work, to it being primarily true, to it always being true. The reason that ideology trumps evidence as frequently as it does is because the methods for dealing with opinion, ideology, and values are not as well developed as are the methods to differentiate between HQE and poor-quality evidence. One does not have a consistent and methodical way of rating the quality of an opinion, an ideology, or a value. The truth is that we tend not to perform these activities explicitly. The professions look at the world through their lens and this colours their view of what is best in the larger community interest. One response to this would be improving the way we educate the health professionals to ensure that they take a broad view of the effects of the health care system on population health.

A second response observed that the craft of policy making was in being able to successfully have ideology, opinions, HQE, and values work together in the public interest. Policy makers felt that differentiating among ideology, values, opinions, and HQE was essential; however, the difficulty comes in apportioning how much weight to be put on each of those. In addition, not all issues would contain characteristics of ideology, values, opinions, or HQE. No policy makers were able to identify explicit mechanisms to do this. One suggestion was to make the process entirely open and transparent to the public and stakeholders. In the two provinces, the closure of 52 hospitals in Saskatchewan and the issue over Bill 11 were identified as the most difficult issues, where there was a clash of HQE, values, ideology, and opinions. Interests made it difficult to resolve satisfactorily; however, in the end, the issues were resolved satisfactorily, meaning that the governments shepherded through the changes without any significant change to the policy course.

Policy makers expressed the view that all the actors had important roles to fulfill. Two observations were that effective leadership from a Minister and Deputy Minister were paramount for the success of moving a reform agenda forward. In addition, it was suggested that researchers take the opportunity to spend time gaining experience in the worlds of the policy maker and the politician. Finally, it was noted that an informed policy decision was not the same as an evidence-based decision.

Policy makers in both provinces stated that an increase in funding for HSR was necessary to achieve improvements in health care policy making. The encouragement of effective linkages between the producers of knowledge and policy makers was deemed particularly important where shared learning could take place. The creation of incentives to use HQE in policy making was noted, as was the opportunity for researchers to be involved in projects from conception to implementation.

Researcher

Does ideology trump HQE?

By and large, researchers from both provinces agree that most often ideology will trump evidence but there are some qualifiers. As one researcher from Saskatchewan said:

> *...it's pretty rare now that ideology would trump evidence forever. Yes, people will make decisions based on their ideologies and their hunches and so on. And in the short run, they may be sustainable. But if consistent research shows that it's not a wise decision, even on its own terms, that is it doesn't get you the objectives that you said you were in favor of pursuing. The truth will* [win] *out and I think it will become a political liability if you just persist and don't change. The high quality health services research does tend to get out now. It does tend to get into the media. There's a huge appetite for it. So, maybe this is naively optimistic, but I think at the end of the day, and it may be a longer day in some jurisdictions than others, but at the end of the day, validity will win out and will influence behavior.*

One researcher from Saskatchewan, like the policy maker from Alberta, felt that trump might be too strong a word:

> *I think that it is true. "Trump" might be a strong word, okay, but I do think it ...significantly does affect policy. Perfect example of that, quite frankly, is the way we should remunerate physicians ...Inherently, I know that there are better ways of doing that. Government knows that there are better ways of doing that in terms of getting a, sort of, results-based delivery system...*

Alberta researchers held a less favourable opinion, making observations that there is very little evidence to tell us exactly how much HQE is being used to inform policy making but to believe otherwise would be folly. HQE is more likely to be used where it matches the politician's or policy maker's predisposed ideas or what they wish to do: Bill 11 was identified as an example of where ideology did trump the evidence. In fact, there was a lack of HQE. One researcher stated that it is very difficult to know how a policy maker can stand up to a politician, or if they can or should. One researcher pointed out that in one-to-one conversations with politicians, policy makers, citizens, and researchers, none of them will disagree with a rational approach – that of using the highest quality evidence on which to base policy – but once you get all of the different interests at play simultaneously, the equation changes, especially if the stakes are high. In his words:

> *If you sit down and talk to someone on an individual level and you make the rational argument around using the best possible evidence to make decisions, then most sensible people are – what could you answer? How could you possibly have said: "Oh no, why would I want to use best available evidence?" So I think in asking that question there may be a built in bias as to what the response is going to be. But, the realities are that when you get all the different interests at play and they're all jockeying for position ...the pressure's on, I think that changes the equation significantly. Especially if the stakes are high. And for governments if there's a possibility of losing votes by using the best available evidence making the "right" decision...*

One researcher described the dichotomous situation that arises between the conflicting goals of politicians and researchers in the following way:

> *Science spends a lot of time trying to refine the question so that it is answerable - it makes the question clear, clean and focused. These are all necessary efforts that ensure that the research is of a high quality, unfortunately all of the kinds of things that lessen the generalizability of the findings. To do other wise you don't get HQE. So by making the research question answerable it renders its broader contextual meaning less relevant to policy makers or politicians who must take a wider range of considerations into account. The political process on the other hand takes a very broad view and tries to take into account all of the important and relevant factors. Add to this the dynamic of having to worry whether you are going to have a job and you begin to understand the dynamics taking place in the minds of politicians or policy makers. So a politician is not going to want to distil something into its finest form but rather they want to see the big picture and leave themselves some freedom to manoeuvre. They have to be able to see across jurisdictions and take a balanced view. It's a very different view of the world. Politicians need to appeal to the greatest number of people whereas researchers need to answer a specific question.*

Another researcher recounted a scene from the popular English television series *Yes Minister,* where a Minister is about to make a decision based on what is right, rather than what is popular, and the bureaucrat responds, "Minister that is a very courageous decision you are about to make." This observation underlines the situation that arises when the right course of policy action may very well be fraught with controversy and the politicians may need to apply a calculus to determine whether the consequences of proceeding with the policy action may not compromise the viability of the government.

An Alberta researcher pointed out that "*belief in rational science could be an ideology.*" This observation captures very well the two levels of analysis of this study. The first is that science as a form of inquiry is a very powerful method at the representational level and attempts to portray itself as operating outside of the social constructions of society. However, at the second level, science needs to be historicized and understood to be a product of the larger social and political circumstances of the period. The observation that is therefore a wise caution to politicians, policy makers, researchers, and citizen elites is that if scientific knowledge is elevated to the position of ideology, its effectiveness and utility comes to be compromised.

Differentiating among HQE, ideology, values, and opinions

The question of differentiating among values, opinions, ideology, and HQE was the most difficult question that respondents had to struggle with. One researcher commented that coming up with a taxonomy to deal with these explicitly in the policy-making realm would be difficult. They all felt that they could do it but their approaches would be different. All of the informants felt that opinions were transient and an expression of a viewpoint. They could either be well-informed opinions or not so well informed; however, they could be rated. The opinions of people could also be arrived at systematically through methods such as polling or focus groups and could be rated.

Values, on the other hand, were felt to be more fundamental, something less prone to being transient, and could also be arrived at empirically and systematically and be rated on whether people had firm or flexible values. Analysis could also take place to identify values and their content. Unlike opinions, which could be well informed or not, values did not appear to be as easily rateable; however, it did appear that one dimension of values was whether they were flexible or firm. One researcher stated:

> *Everyone holds values and the test of those values is how do you hold onto them? If you hold on to them in a fundamentalist way, then to me they're indistinguishable from ideology. But if your values are more thoughtful, more nuanced, recognized as at least somewhat contingent and testable and challengeable by evidence, then I think that's a sound way to hold on to values.*

Ideology was described by one informant as a rigid set of ideas not to be changed by evidence; it is a closed intellectual shop and it is dogmatic. The researcher admitted that this was his Western liberal intellectual tradition coming through. One person pointed out that values and ideology are not that different; values are the positive side of the coin and ideology the negative side – the more pejorative. For example, if one wanted to dismiss another person's values, one would refer to them as ideological and that in itself would be enough to bring them into question. One researcher articulated it this way:

> *I have a lot of difficulty expressing the differences between ideology and values. So some people will dismiss things by saying, oh well that's just plain old ideology as indeed the Health Minister in this province did with Romanow Report ... he had not read it. Hadn't had his briefing at that point in time and dismissed it publicly saying that was ideology. Now what did that mean when he said that? Did it mean that it was less valuable than his set of views because he had a different ideology? And how much is ideology separable from values? Well if ideology here speaks to, for instance political ideology, and he dismissed Romanow material as that's all ideology, what he was probably saying too is that the apparent values that underlie the Romanow Report seem to be very egalitarian in their orientation; they seem to be very universal; very, shall we say, representing the values of solidarity where what falls from that is cross-subsidization and redistribution, all the things we expect from so-called left-wing government. So he dismisses it that way.*

This characterization of ideology in a negative light appears to be consistent across all of the epistemic communities. Another researcher commented that in a contest between ideology and values, he uses an implicit framework that measures their respective performance relative to an agreed set of criteria that are outcome oriented. It was also pointed out that making them transparent and having people explicitly state where they are coming from would make it easier to sort out where people stood on values and ideology. Evidence was perhaps the easiest to deal with because of the amount of attention that has been paid in developing systematic approaches to rating evidence. One researcher observed that contested discourse in science is such that the truth eventually wins out.

Successful strategies for resolving conflict

The researchers identified several effective strategies for resolving conflict among HQE, values, ideology, and opinions. Their predominant focus was for policy makers who must address the question of values and ideology. One researcher commented:

> *...depends what you mean by successful. Some would say the government of the day is elected to pursue its agenda and if it happens to be an ideological agenda it's still got democratic legitimacy and if they decide to press ahead regardless of whether or not there is research that suggests it's the wrong course of action, even though it is on their own terms, so be it. Ultimately it will take the public to judge whether or not that's been a reasonable thing to do. Having said that, I would say that I see fewer and fewer outright conflicts of that nature. So reasonable people tend not to dig in and ... if people are truly ideologues they are not interested in the research anyway. You're not likely to have a clash because they're not going to be in the same room.*

The general view of researchers is that a framework needs to be developed to deal with values explicitly in policy making. One way suggested for this to be done was undertaking studies that identify the values with the issue. The values framework should be described in respect to research questions. Values must talk to the evidence and vice versa. A Saskatchewan researcher stated:

> *I think you have to address the values that ideology is based on. That to me was one of the significant contributions... that was the highlighted part of the Romanow Commission is they actually explicitly addressed values and the title of the report had values in ...the title. In practice, in the real world of decision making, policy-makers must address values. That may be framed through an ideological lens that is based on values so that there is a value fence within which certain of the policy-makers associated with the political point of view don't stray and they won't even consider that. But ultimately you have to address values, evidence and values must talk to evidence and to each other for both to be considered.*

Another suggestion was that policy makers develop a framework and undertake a qualitative study that describes what the values and/or ideology are and what the evidence is and how they mesh. Two other suggestions that have been used to test the public's reaction to a policy direction are to leak reports or float a trial balloon and then gauge public reaction. On the subject of leaking documents, one Alberta researcher recounted:

> *We've seen the examples where politicians will test their ideology by putting it out there in some form of way where the political impact is manageable, controllable... And I have seen this province and this premier therefore modify the decision after they've done that. Which is kind of nice in certain respects. There's parts about it that caused me some concerns, admittedly. But if you were wanting some sense of comfort that when ideas come out from politicians that if you give a strong enough, vociferous response, that the politicians will modify their views, there's some inherent comfort that comes from that.*

One researcher made the comment that researchers should not get too excited about whether something sinks or swims based on evidence – other factors may very well eclipse the HQE. One Alberta researcher observed that the passage of time appears to smooth out the conflicts that arise during ideological debates in health care reform – in spite of all of its warts, the Canadian health care system is something that serves Canadians extremely well. In his words:

> *I always say to my students that, after I've sort of given them the whole gory history of how medical dominance and how the system was shaped around physician interests and that sort of thing, and numerous other examples of where interests come into play, pharmaceutical companies, that sort of thing... you may think that this is all depressing but, the interesting thing about all of this is that some very good things and some very big things do actually come out of all of this. So there are positive results and I would say that the introduction of universal Medicare in Canada is one of the best examples of that. Although again, in making that statement, I'm showing my own ideological predisposition... evidence seems to have made a difference... Has it been the preponderance of evidence that has finally tipped the scale or has it been some other combination of things? You don't really know. But just on the surface it would seem to me that evidence has trumped ideology in the end... Or at this particular moment in time, evidence is trumping ideology.*

Respective value of actors

The question about the value of the four actors was an attempt to understand what the four actors thought of their respective and each other's contributions. Everyone agrees that they all play valuable roles; however, in the end it is the politician who must broker the policy solution. An Alberta researcher made the observation that the value of researchers and bureaucrats in Alberta is very low compared with that of the politicians. The formation of external committees to do things that government used to do is an example of the politicians wanting to take control away from the bureaucrats. One of the observations made was that the importance of researchers could be enhanced in the future if they were to improve the role of qualitative research methods to inform policy questions. This research would require developing standards of scrutiny. An Alberta researcher noted:

> *Qualitative research has always been thought of as second best ... but ... if you understand when and where it's useful I think it's important... I think the field itself has to get some recognition within the traditional paths of its researchers.*

It was also pointed out that if a closer bridge existed between the policy makers and the researchers, their respective appreciation of their roles and value would be improved. The fact that governments have set up independent research agencies suggests that they value these types of efforts.

Respective needs of the actors in relations to HQE

Everyone agrees that the needs are different; however, they should be working with the same HQE. What is different is how they assimillate it, weigh it, communicate it. Researchers need to know what evidence is out there, to identify the gaps, and to respond to them. Policy makers become the prime target of the evidence and they then use it to form policy alternatives for the politicians to consider. Policy makers filter the evidence for the politician. Politicians, on the other hand, need to balance the larger public interest with what will be publicly acceptable and they will of course favour evidence that supports their particular paradigm or policy position. Two other observations of interest are that everyone is scanning the literature looking for evidence to support their case and far more people are bringing evidence to the table today than was the case in the past.

Improvements for the future

The responses from Alberta and Saskatchewan researchers agreed on the fact that improvements in the policy and decision-making process needed to ensure that it was open, explicit, and transparent to all parties and that some attention to holding people accountable for not using evidence needs to be considered. One approach suggested building rewards and incentives into the policy-making process in the use of HQE. One way would be having the academic tenure review process give credit for undertaking projects on behalf of policy makers. Developing some mechanisms and outcome measures surrounding the policy implementation using HQE would be one way to start to get a formal understanding of this. A Saskatchewan researcher stated:

> *I'm a big believer in performance measurement... it would be nice some day to have a ...report that said, "In the last year the policies of the, name your jurisdiction, were on a 1 to 10 scale, or however you want to rate it, backed by solid research findings where possible. Or that their organization, the ministry, the region, whatever, is a research aware, research literate and research using organization. And I think that will actually get more done and accelerate the use of research and cement some connections between research and policymaking that is still pretty haphazard now. It's voluntary. You know, there's no great price to pay for making a decision that doesn't have a research basis now. It's getting better but still we haven't ..."belled that cat" and people aren't held to account for it. So, how do hold people to account? First of all you have to be able to measure ... you have to describe what accountability is and you have to measure the extent to which they're meeting it or fulfilling it.*

Another suggestion was that improved processes be introduced for the public to enter into the policy-making process and that the public involvement be treated in a genuine fashion. Those who deliver care were also identified as being helpful to inform the policy-making process but they should be encouraged not to be dominant as they have in the past. An Alberta research leader stated:

> *...and secondly it really is time that more people that actually were involved with the care of individuals found their way into the public policy*

> *formulation mechanism... People that have accepted the responsibility of providing care and services to others have vanished from boardroom tables and policy-making tables and FPT deliberations.*

Several researchers also pointed out that the capacity of the Department of Health should be improved so that they are able to do more research internally to inform some of their questions. A Saskatchewan researcher pointed out:

> *I think, again, I can't speak for Alberta but I think policy departments in government ... have to be a little bit more free-thinking and original. I think our policy branch in Saskatchewan is now spending a lot of time responding to some fairly immediate issues that get referred to it...one of the tragedies of our time... is that we don't give our policy and planning branches the opportunity to sort of play ... So, if I had to make one change, I would have a protected day a week, or something like that, for P [policy] and P [planning] to say "We don't take any messages for the Minister's office that day." You do sweet-tweet. You ignore everything that has gone on from Monday to Thursday. Friday is your "blue sky" day. I don't think we do nearly enough of that.*

Finally, one researcher made the observation that democracies work best when there is a small majority or minority governments; in those situations, all political interests have to sit down and work together to hammer out a solution that is best for democracy and the citizens. The Alberta researcher noted:

> *To improve the policy process... Probably paying more than lip service to best available evidence ...having better public representation within the decision making process rather than sort of paying lip service to what the public want...I guess being more genuine about public involvement rather than simply paying lip service to it. And I would say having an effective Opposition...my feeling is that a healthy democracy is a good thing and some of the best decision making historically in Canada anyways has been made in situations where the government only has a small majority or whether they're in a minority situation and therefore all of the political interests have to work together and hammer out a compromise.*

Summary

Researchers point out that to believe that ideology does not trump HQE would be folly. However, there is a general perception that eventually HQE does win out. One of the challenges with this question is that no one has studied the use of HQE in Alberta or

Saskatchewan and so it is difficult to know how well HQE is used. It is also likely that evidence that is commensurate with a policy maker's or politician's point of view or intended action is given a privileged status. One researcher raised the question of how far a researcher can legitimately go in raising a case of where HQE is being trumped by ideological interests. Is it legitimate in a democratic civil society for a researcher to take issue with a policy maker or politician? The observation was also made that in a one-to-one conversation, everyone agrees that we want the HQE to inform the best policy; however, once you bring everyone into the mix and interests begin to be manifested, this changes the dynamics of the formula and the outcome is not necessarily rational. The mechanism by which science works to come up with clear and concise answers is also antithetical to how policy makers and politicians work, as they may need a broader perspective and some room to manoeuvre.

Researchers approached the question of differentiation of evidence, ideology, values, and opinions much more systematically than others pointing out either implicit or explicit techniques they used and felt could be helpful. In respect to successful strategies for resolving conflicts, researchers all agreed that there was need for some framework or model that allowed the values, ideology, and HQE to be explicitly factored into the policy-making process – some process of accommodation. One other suggestion for testing the public sentiment was to gauge the public reaction through trial balloons.

On the question of relative value of the epistemic communities, researchers felt that they were all important, but in the end the politician must broker the policy solution. One researcher felt that the establishment of the Standing Policy Committees is an attempt by the politicians to take some of the influence away from the bureaucrats and researchers. On the needs of the four actors, they were all identified to be different and how they assimilate, weigh, and communicate the information is very different.

In respect to improvements for the future, researchers in both provinces affirmed the need for research to be open, explicit, and transparent. A Saskatchewan researcher suggested that if policy making were held to a high standard of accountability for using HQE, its uptake would be improved. Researchers felt that genuine public involvement rather than lip service to it was necessary. An Alberta researcher stated that the swing away from dominance of public policy decisions by care providers has now become harmful because their perspective was being lost in the policy-making process. Policy makers in both provinces expressed a concern with the reduced capacity for effective policy making in the departments as a result of downsizing. The morale and commitment to best practice in policy making was seen as the way forward. Finally, an Alberta researcher suggested that a stronger challenge function to government was healthy for good policy making to take place.

Citizen elites

Does ideology trump HQE?

Responses from citizen elites in both provinces ranged from absolutely ideology does trump evidence, to it happens regularly (predominant point of view), to it happens less now than in the past. None of the citizen elites felt it did not happen. Those pointing out that it happens regularly point to the fact that health reform has not been happening as quickly as the governments would have liked, particularly when it comes to promoting the primary health care model of physician service delivery. Setting up the processes to institute reform is much easier to do than to facilitate the actual reforms. One citizen elite from Saskatchewan identified it as being vested interest gridlock and governments being complicit to it. In his words:

> *Absolutely true, end of story. Vested interests were... why ... reform [is] not going ahead – vested interest gridlock. ...don't take vested interest as just being the physicians and the nurses. Vested interests are also the government. Why are the governments refusing right now, why are the Ministers of Health so afraid to set up and appoint an independent national health council? Well, it's really saying that they don't want to be accountable to the public. Because what have they've got to hide? This national health council is not going to tell the Minister of Health in Saskatchewan what to do. But wouldn't it be nice for the Minister of Health to know a lot more of what's going on. But also the fact that there's an amputation every other day from complications from diabetes, don't the people of Saskatchewan have a right to know that? So what are the Ministers afraid of? It's the publics' money. So we are locked in many vested interests of why this primary health reform, why this primary*

> *care, primary health does not move ahead. It doesn't move ahead for a lot of reasons, incentives, but also power structures, vested interests.*

Another Saskatchewan citizen elite characterized the professional associations driving the health care policy agenda by virtue of cloaking their arguments in the public interest or quality care when in fact they are really the self-interests of the profession. It is not always only about money and protection of their incomes but power and control enter into the equation as well. The citizen elite stated:

> *...in the not-too-distant past I would say that that is 100% true. It is becoming less so, but it is still frustrating to the extent to which ideology and vested interests do influence the system ...principally through the medical associations, often drives the public policy agenda in a way in which it is cloaked in terms of public interest and quality that is fundamentally driven very much by physician self-interest and I am not talking here just about money, but I am talking about maintaining control and power. So, on primary care reform, I mean you have agencies boldly saying to the government "look, we can totally block this or we can help ... unless you work with us, nothing is going to happen." And that is sheer power of politics. I think that is unfortunate. But, it is reality. So, I think that as the quality of evidence and the capacity to explain it in an understandable way to the public improves, I think it disarms the potential for vested interests and ideology to trump. But, sometimes, it is still the case that it will trump.*

One of the citizen elites gave the example of a drug for multiple sclerosis (MS), which had not been shown as clearly clinically effective for all cases of MS, but one Minister was in favour of it. Public support was mobilized to the legislature and within weeks the drug was added to the provincial drug list. The likelihood of ideology trumping HQE in the past was in one view very true; however, the champions for HQE continue to advocate their position, although on some occasions the politician or policy maker will rule over it. Perhaps in time the balance will swing in favour of the champions. An Alberta citizen gave the example of the private versus public health care debate as another example where ideology continues to trump the evidence. The citizen states:

> *The Canadian health system is a good example of ideology where people will say, "Well, we're not looking at the convenience or the standard care for an individual citizen. If care is delivered in some fashion that someone makes a profit, it's wrong and it's bad and this would never happen."*

> *And there's still a lively debate going on about that and on the other side of that being ... if the objective is to treat or cure this person, does it matter how we do it or who does it? Whether it's private or public or quasi-private or a union or a consortium or... does it really matter if we get the objective done? Which would probably inevitably end up with a mixture of public, private, government and everything else. So that debate continues although I think it's of less currency now than it was about say the early nineties.*

This observation is representative of the common confusion between the ends and means distinction surrounding the private delivery but public funding of the Canadian health care system.

Differentiating among HQE, ideology, values, and opinions

Differentiating among values, opinions, ideology, and HQE was confirmed to be a tough question among citizens. Opinions may change daily, whereas ideology and values do not change over time. Another said that a person has the right to his or her own opinions but not to their own facts. One citizen observed that some believe if you transfer the cost of health care from the state to the individual, you save money. In his view, that is a belief and there is no evidence to support it. With an incorrect belief or opinion, you compromise equity, which is a value. One way out of this is to be explicit and open about our values. We need mechanisms and processes where we bring the scientific and ideological conversations together to discuss and debate the issues. A Saskatchewan citizen stated:

> *Values are important...they really are. I think it is important to use the forums where we do get our values declared...where we do get them on the table. What is frustrating is when a policy decision is driven by invisible values. I think transparency is important.*

To be trusted by the public, the process would need to be open and transparent. Scientific views and ideological positions could be melded openly. An informant stated the need to be critical with all information – even from authority figures. A person should be able to substantiate the basis of their opinion. "*If someone can refer to good evidence I am more likely to believe it.*"

Successful strategies of resolving conflicts

Alberta citizen elites did not provide many examples of successful strategies other than pointing out that it takes a long time to change the minds and hearts of people. Citizens need to be consulted and they will very quickly point out where information is wrong. Saskatchewan citizen elites felt that ideology may win in the short run until the issues start – then they look for the evidence. Governments go through cycles, looking to the marketplace to solve public issues, and when they run into big issues, they begin to look for evidence and see that it requires some public diligence. In some cases, politicians have sided with the evidence and lost elections because of it – the people get the final word. Time will oftem allow the evidence to prevail. A high-profile issue that has a strong emotional element may make it difficult for evidence to have influence.

Relative value of actors

In response to the relative value of the actors, citizen elites from Alberta were fixed on the largest influence being from politicians. As one put it:

> *...a politician faced with a decision in which his re-election is based on what he decides to do has an impact on how evidence is used.*

Only one of the three Albertans put citizen elites at the top of the hierarchy. All of the citizen elites from Saskatchewan felt that citizens' input should be much more highly valued in the process, as well as input from researchers. In addition, Saskatchewan citizen elites felt that marketing good-quality research is important. They also felt that well-informed citizens are better than misinformed citizens to drive healthy public policy. We need to work on how we inform our citizens and if the process were to work from the ground up, rational policy choices should be the result. We need to give the citizen a higher profile role in informing policy directions. Finally, a Saskatchewan citizen elite observed that researchers should not let their egos get in the way of quality evidence.

Respective needs of the actors for HQE

Alberta citizen elites identified the following about the needs of the four actors. Policy makers were there to help politicians define what the citizens wanted or needed. This role of politicians has changed to some degree and politicians are telling the citizens what they should want based on HQE. This may be an appropriate role for a politician but it may not be an appropriate role for a policy maker. Policy makers that articulate a policy change based on HQE that runs counter to the sentiment of the public and politicians may be in dangerous territory. Policy makers and citizen elites pointed out that a lot of expertise has moved out of the department, leaving a void in the government. An increasing political environment demands taking into account the political dimension of policy making. If policy makers are not competent in using HQE, then values and ideology rush in to fill the void at the expense of the evidence, resulting in poor policy development and implementation. It was pointed out that the actors need the information in different forms. The information for politicians needed to be boiled down because they have little time to review the evidence. The need for information on the part of all actors is similar, but how they interpret and use it is different. Finally, the observation was made that we need to agree on a process for ensuring that wise use of information is made and not "monkey" with it when it tells us something we don't like. As one citizen stated, "*Bad news may be good information.*"

Saskatchewan citizen elites felt that policy makers were often filtering or sifting information (separating out what they felt was important from the unimportant) for politicians in order to quickly brief them. The policy makers take into account what they know about the politician's framework and modify or supplement the research evidence. Other comments noted were that all actors need to be able to communicate at an appropriate level. With respect to the type of information, researchers and policy makers should be looking for as much rigour in their information as is available. Researchers need to find interesting ways to communicate their findings. It was agreed that everybody needs HQE, but the form they need it in is going to be different: the spectrum of evidence gets wider and higher as you go up the policy-making hierarchy. Citizen elites did not feel they needed the detail of the evidence, only the summary. The observation was made that issues of entitlement may not be able to be resolved with scientific evidence; these may be questions of value. It was also agreed that it was much more likely to come to a successful resolution if the values were explicitly on the table and people were not hiding behind them.

Improvements for the future

Citizens of both provinces provided several ideas on how policy making and the use of HQE could be improved. A large number of comments can be categorized into improvements in the process of policy making by providing more opportunity for citizens to be brought into the discourse. Two of the suggestions from Saskatchewan citizen elites were developing appropriate incentives so that people seek using HQE and creating linkages so that people are asking relevant and researchable questions. One citizen felt that the development of an explicit decision-making model (like the ethics one) would be helpful in defining what good policy was. One citizen identified a necessary reinvestment in high-quality people, particularly in the public service, to improve the data available for the policy-making process. A Saskatchewan citizen elite stated:

> *...there's also a movement to... have better data. ... look at Saskatchewan's Quality Council ... look at the team on there ... They're going to shake things up ...*

A Saskatchewan citizen elite pointed out that the dissemination of HQE into the public arena needs to take place and the use of that information needs to be demonstrated:

> *I think even better dissemination of evidence into the public arena is probably the single most important recommendation for future health policy development...I think in terms of better engaging citizens in this dialogue and to help them inform the policy making process, probably one needs to more frequently frame different policy options...we probably need to do a better job of helping the public understand the implications of different choices.*

A second Saskatchewan citizen felt that:

> *Where the research is done, communicate it; try and make it transparent... Where the research isn't done, do it. Information, you've heard me say this part, information works better if you use [it]...the biggest thing that's facing the health system is starting to get the information out there to make it effective and efficient. And break down self-interests.*

Suggestions from Alberta were to look at municipal governments, as they seem to be effective in bringing citizens into the process of policy making. One Alberta citizen stated that:

> *...some of the strongest... policy creation and most innovative is that that I've seen done at a local or community or municipal level. And the reason that I find it's effective is because it's open ... so anybody can participate. It is participatory. It usually requires a source of new information ... and, it often takes a while for the community to buy in, but once they've bought in they're very supportive of it. And so grass roots policy making ... is some of the strongest policy development that you can have.*

It was pointed out that people should be permitted to fulfill their roles and that politicians should not run interference. The establishment of appropriate rewards and penalties for the effective use of HQE was identified. One citizen pointed out that there was a need for policy makers and politicians to have broader systems thinking and that there are no silver bullets to the issues facing the health care system.

The issues and problems are complex and so are the policy solutions. One citizen suggested using pilot projects and examining what might be unforeseen benefits of these types of policy experiments. The policy experiments are not often thought of, but they should be encouraged and their outcomes should be viewed as a learning experience rather than as a partisan exercise. An Alberta citizen stated:

> *I'd like to see the future policy development be more open to public scrutiny. And I'd like the policy-makers themselves see a given policy more in a research vein .... So set up the parameters for evaluation of the policy at the time that the policy is implemented. So, what do we consider success if we implement this policy. What will be adverse effects that we will consider if this policy is implemented? What are we going to look for in terms of potential unforeseen benefits of this policy? And then, in other words, look at it more as a learning mechanism instead of a partisan position. So if we made it more transparent and to the public and we look at the policies in a much more evaluative way, I think we would learn from our public policies and be more responsive to the public interest.*

Suggestions were made that better communication among the various elements and programs of health reform should be encouraged to avoid the silo mentality from being reintroduced in the health care system. The full implementation of the Rainbow and Mazankowski Reports were also identified as desirable.

Summary

Citizen elites generally felt that ideology does trump HQE but not as frequently as it used to and it is expected to happen less in the future. It was also pointed out that setting up the framework and mechanisms for health reform is easy; the hard part comes in actually making changes in the way health care is delivered and how professionals are remunerated. One citizen elite identified the lack of progress on health reform as being due to the fact that health care policy is in a vested interest gridlock. Those in the delivery of care are not willing to make changes that would be in the public interest by sacrificing any of their financial position and power. One begins to understand why politicians might become so frustrated in a health care policy-making process that they cannot break the gridlock and advance efforts in the community interest. Perhaps the introduction of the free market in health care is the only way to achieve changes that cannot be achieved through what appears to be an ineffective form of public management.

Citizen elites tended to feel that systematic processes should be developed to make open and transparent the values, ideology, opinions, and HQE being brought to bear on an issue. Open deliberative discussion of these should arrive at better public policy than doing it in isolation without that input. Examples of effective strategies identified were appreciating that governments go through cycles and that time would render some issues as having currency with the public at one time versus another time. On the question of relative value of the actors, Alberta citizen elites felt that politicians were the most influential. Saskatchewan citizen elites felt that citizens should be much more highly valued in the process. Citizen elites identified the needs of the four actors as similar, but how they use and communicate the information is different. Effective communication of the HQE was identified as a strong need on the part of all informants.

Citizen elites from the two provinces were consistent in their identification of opportunities for improvement. Meaningful participation of the public was identified as important. Resonating with the advice of researchers, citizen elites felt that incentives needed to be introduced to encourage the use of HQE. A Saskatchewan citizen elite was emphatic that competent people be used to inform the policy process to ensure that the best advice and commitment to best practice was achieved. Citizen elites also felt that the creation of HQE was not enough by itself; it was through successful demonstrated use that it really became valuable as an asset for policy making. Finally, an Alberta citizen elite identified the need for rigorous systems thinking about problem solving, breaking down of silos among the different elements of the health care system, and the use of pilot projects to test ideas for improving health care services delivery. An Alberta citizen warned that pilot projects may involve bringing in ideas and expertise from the private sector and that these should be tested under controlled conditions to see how they could help resolve problems and issues in the public sector.

Conclusion

Tables 25 to 27 provide a tabular representation of the findings in this chapter. It is instructive to note in Table 25 that among politicians, Albertans were more likely to feel that ideology trumped evidence, while Saskatchewan politicians felt that evidence does eventually manifest. Saskatchewan policy makers felt it was partially true, while Alberta policy makers were split in their perspective. Researchers between the two provinces were essentially in agreement that it was mostly the case. Citizen elites, on the other hand, felt overwhelmingly that it was the case that ideology trumped evidence.

Table 25: Summary of Informant Response by Province as to Whether Ideology Trumps HQE

INFORMANT	DOES IDEOLOGY TRUMP HQE?	
	ALBERTA (*N* = 12)	SASKATCHEWAN (*N* = 12)
Politician	Yes (3)	No, may be delayed but eventually the truth does win 'out' (3)
Policy maker	Loaded question (1) Yes (1) No (1)	Partially true (3)
Researcher	Mostly true (2) Hard to know without hard evidence (1)	Too strong a word (1) It may but not forever (2)
Citizen Elite	Yes (3)	Yes (3)

Note. HQE = high-quality evidence.

Table 26 illustrates how the epistemic communities felt about differentiating among and between evidence, values, ideology, and opinions. The way in which politicians differentiate among and attribute weight to evidence and other forms of ideas that circulate around issues is very weak. A difference noted between the provinces was that it does appear as if Saskatchewan politicians have more experience than Alberta politicians in talking about the differences. All politicians, however, agreed that it was important to do properly, although they could not identify specific techniques to carry it out. Policy makers were more informed about differentiating but few could identify tools by which to perform this task. Researchers were quick to differentiate among evidence, values, ideology, and opinions and to identify tools that would help to critically appraise the quality of them. Citizen elites were aware and supportive of reasoning through the differentiation and having values and evidence speak to one another. The identification of this gap between the politicians and policy makers, the expressed desire on the part of citizens to see it done effectively, and the knowledge of researchers to provide support in this area suggests that bringing the parties together to deliberate on how to educate politicians and policy makers to effectively differentiate between evidence, values, ideology, and opinions could advance the evidence-based policy movement significantly. This will be addressed further with the proposed model in chapter 10.

Table 26: Summary of How Informants Differentiate Among Values, Ideology, Opinions, and HQE

INFORMANT	DIFFERENTIATION OF VALUES, IDEOLOGY, OPINIONS, AND HQE	
	Alberta	**Saskatchewan**
Politicians	Differentiate between means and ends	Deliberative choice method Cross-examine the data Separate fact from value
Policy makers	Gut feeling	Deconstruct evidence to look for ideology Look for cloaking of ideology as evidence
Researchers	Need to be explicit and transparent about them Develop an instrument to do it	
Citizen elites	Open and explicit Have evidence speak to the ideology and values	

Note. HQE = high-quality evidence.

Table 27 illustrates the views of the epistemic communities about successful strategies for resolving conflict between and among evidence, ideology, values, and opinions. All the informants had experience with and were conversant with methods and techniques that could be used to resolve these conflicts. Politicians felt that the public needed to be kept apprised of the issues, as ultimately they were the final arbiters of government. Citizen elites felt that public forums could be used to achieve this end. All the informants were supportive of one another about employing successful strategies to facilitate what one politician referred to as "separating the signal to noise ratio" (S/N); what really counts in these issues and what is a distraction? The message that strategies should involve citizens, use techniques to separate the S/N ratio, and be open, explicit, and transparent to all parties will be introduced in the model developed in the last chapter.

Table 27: Summary of Successful Strategies for Resolving Conflict

INFORMANTS	**SUCCESSFUL STRATEGIES TO RESOLVE CONFLICT**	
	Alberta	**Saskatchewan**
Politicians	Get public on side Keep realistic expectations Use fiscal imperative Separate signal/noise ratio	Each actor focus on their role Open and transparent debate Manage the conflict
Policy makers	Practise craft of reconciling Eliminate staff causing conflict Postpone decision	Be open and transparent Interrogate issues Let communities decide Use fiscal imperative
Researchers	Elections Undertake studies of values and have them speak to evidence	Need to address values studies Develop framework Leak reports and trial balloons
Citizen Elites	Passage of time	Use public forums

The suggestions for improvements in the future from the epistemic communities appear to be a desire on the part of all the actors to see a more open and transparent evidence-based approach utilized and practised in health care policy making. A summary of improvements is tabulated in Table 28.

Table 28: Summary of Improvements by Informant and Province

INFORMANTS	IMPROVEMENTS FOR THE FUTURE	
	Alberta	**Saskatchewan**
Politicians	Organize summits Credential evidence Increase research capacity Prioritize health research agenda *Education opportunities for MLAs*	More resources for research National health council to adjudicate Explain issues to public
Policy makers	Increase capacity of universities for research Demonstrate leadership for use of HQE Create proper incentives for use of HQE Develop embedded linkages between research and policy-making communities Encourage researchers to develop communication and implementation plans for their findings	
Researchers	Open, explicit, and transparent processes Hold policy makers accountable for use of HQE Introduce rewards and incentives for use of HQE Develop mechanisms and measures to determine benefits of using HQE Improve the opportunity for public involvement	
Citizen elites	Provide linkages between researchers and policy makers Develop and introduce an explicit policy-making framework Invest in high-quality people Disseminate the evidence to the public Broaden policy-making community to systems thinking Introduce incentives and rewards for creating and using HQE	

Note. HQE = high-quality evidence; MLAs = members of the legislative assembly.

As shown in Table 28, politicians are in support of more education for themselves and for citizens in respect to how to be critical about deconstructing the evidence, values, ideology, and opinions surrounding an issue. The politicians in both provinces are also committed to seeing an increased commitment to supporting the research enterprise that will help inform relevant policy issues and questions. Policy makers agree with the need for more resources to be allocated, but they also point to the need for expressed leadership and creation of appropriate incentives to encourage evidence-based policy behaviour. Creation of embedded linkages and looping researchers into the communication and implementation plans would also improve the relationship between researchers and the policy community. Researchers echo the need for incentivizing the system toward evidence-based policy making but also encouraging an open, explicit, and transparent process that maintains each party's autonomy and engages the community. The need for building in an evaluation process to determine the impact of the research to evidence and, in turn, the population health was underscored. The citizen community was supportive of these efforts and also underlined the need for well credentialed and qualified people to undertake the work. These salient observations will be utilized to help build the model in chapter 11.

SECTION FOUR: DISCUSSION

Chapters 11 and 12 form the concluding section of the thesis. Chapter 11 synthesizes the data and themes derived from the GT approach to the interviews, and it reflects on the questions raised during the metatheorizing about epistemic issues and the theorizing about the relationships among society, state, and knowledge. Chapter 12 concludes the thesis with a reflection on the theory and model building developed in chapter 11. It also identifies opportunities for future research.

The core intent of this section is to reconstruct an empirical model that could inform policy reform and to develop practical models that might aid political deliberation. More specifically, in building empirical theory and constructing analytical and metaphorical models of how health care policy making may be improved, I return to the central cultural elements of narratives, values, and explanations and review the insights from the literature and the informants to understand and evaluate why there is a gap between the research community (in Alberta and Saskatchewan) and the policy community.

Three models are derived from the theory. The first, grounded in empirical data and abstracted as an analytical model for policy making, highlights *best practice* for policy making and research, *linkages* between policy and research communities, *accommodation* of dissonant ideas at the policy-making table, and *traction* of policy to monitor so that the health of citizens does not take a step backward. This model is also alternatively represented metaphorically as a "spinning top." Two other models for the implementation of the theory are also developed. The first of these, called STEEPLE, is a mnemonic guide to help policy makers apply the social sciences more effectively to health policy making. The second is an elaboration of the guide and consists of a series of practical checklists for beginning a conversation among policy makers about the establishment of best practice, improved linkages, open accommodation, and effective traction.

Chapter Eleven

Theory and model building

Background

The research question of this thesis was, "What was the interplay among evidence, values, ideology, and opinions during health reform in Alberta and Saskatchewan from 1987 to 2003, and how can this knowledge help inform politicians, policy makers, researchers, and citizens on how to improve the health care policy-making process in the future?" The research question arose from my observation and experience in health care policy making that scientific evidence would often be overlooked or overpowered by other influences such as interests, values, ideology, or opinions. In other cases, scientific evidence would dominate values without a meaningful exchange between them. Pragmatic considerations, at times, would appear to lead policy makers to delay or avoid policy actions that might be in the best public interest, but the controversy surrounding the issue prevented bold policy action. One example is the contemporary debate on banning smoking in public places or replacing the fee for service of physicians with salaried remuneration. The first is an important public health effort that would reduce the incidence of lung cancer in the community and the second would remove perverse incentives that encourage volume-driven medicine rather than quality-driven medicine. The values, ideology, and opinions that often influence policy decisions do so without having been interrogated rigorously to ensure that they represent the highest quality values, ideology, and opinions.

Introduction

Chapter 11 is the synthesized culmination of the research undertaken to answer the question. It provides a brief review of the approach taken in this project. The salient findings of the three literature reviews are noted and pulled into a discussion of how they inform the building of a theory and model that may advance and improve the quality of policy making in health care. The findings of the interviews are reviewed with the same intent: to identify ideas that would help to improve the health care policy-making process in the two provinces. A theory of health care policy making is derived, illustrating how it may be effective in doing two things: (a) creating a mechanism that allows the opportunity for values, ideology, and opinions to be brought to the policy-making table in a systematic, open, and explicit way; and (b) ensuring that all evidence, whether scientific or values based, is brought to the policy-making table after having been rigorously assessed. Two pragmatic models for the implementation of the theory are developed. The chapter concludes with my assessment of the strengths and weaknesses of the model, as well as opportunities for future research.

The approach

The GT approach focused on these selected four actors to explicate the understandings and perspectives about the role and influence of scientific evidence and values in health care policy making. The concept of epistemic communities was used to describe the groups of actors who shared a set of normative and principled beliefs. These beliefs served as a foundational rationale for their social action. The four actors selected for this study were politicians, policy makers, researchers, and citizen elites. Although interest groups, political parties, and institutions would have had an influential role in health policy making, this project focused only on the four actors. The influence of the former would have been mediated by the latter through the political processes and these remain unaccounted for in this thesis.

To supplement the information gleaned from the interviews, I conducted a review of the literature to gain a better understanding of the following:

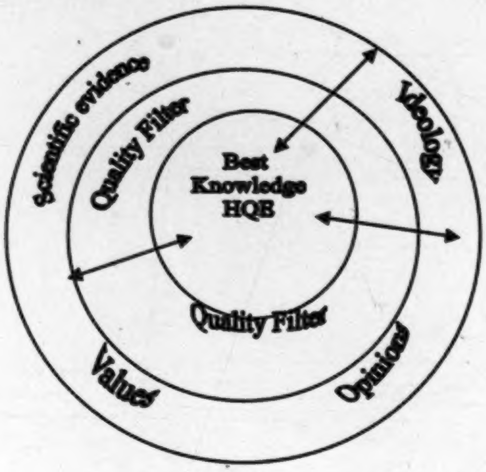
- The use of knowledge, research, values, and ideology and their influence and relationship to policy making
- The role of the state in health care delivery and policy making
- The narrative stories examining health care policy making and the analysis for reform in Canada

A purposeful sampling technique identified an equal number of informants ($N = 24$) in Alberta and Saskatchewan for interviews. The interviews were conducted between July and October 2003. The data from the interviews were transcribed and divided into multiple themes, which were in turn collapsed into the four themes described in chapters 7 to 10. The themes arising from the interviews provided an understanding of the current problems, issues, barriers, and confounding factors to using HQE (whether scientific or otherwise) in the policy-making process. The purpose of the remainder of this chapter is to develop the theoretical model(s) in an attempt to answer the research question of how health care policy making can be improved.

Review of HQE and best knowledge

This project has demonstrated that there is a significant gap separating the creation of best knowledge and its use by the policy-making communities in Alberta and Saskatchewan. In the course of this study, best knowledge is not assumed to be synonymous with research evidence; rather, it is research evidence (in its many forms) that is of high quality. Best knowledge is also not simply the accumulation of quantitative or traditionally "scientific" evidence: it is also evidence of values, ideology, and opinions that has been derived through qualitative or mixed methods to enrich a mosaic of evidence that forms the bricolage of best knowledge. Figure 6 illustrates a structure and relationship of best knowledge being constructed on a foundation of high quality: scientific evidence, values, ideology, and opinions.

Figure 6: Best knowledge, quality filter, scientific evidence, values, opionions and ideology. HQE = high-quality evidence.



Between the two provinces, it appears as if Saskatchewan has developed more nuanced methods of bringing HQE in to inform its policy-making activity than is the case in Alberta. The members of an entire senior bureaucratic team in Alberta were dismissed from their jobs when they could not find scientific evidence to support private delivery of health care over public delivery. The fact that the evidence could not be found was assumed to be a symptom of staff incompetence or an attempt to subterfuge the information for ideological reasons. Even though Saskatchewan appears to be more progressive in using HQE in health care policy making, both provinces find it challenging to complement scientific evidence with other forms of evidence from the social sciences at the policy-making table. Although values, ideology, and opinions do influence policy making in both provinces, they often do so in crude and unsophisticated ways. The ability of politicians and policy makers to differentiate values and ideology from scientific evidence appears to be low. Few could identify a specific means or tool that could be used to help differentiate between them and even fewer could provide examples of how they could be differentiated. Although it is not possible to suggest what values or ideology should dominate in a policy discussion, the opportunity ought to be facilitated to use standardized and consistent methods of articulating the HQE about values or ideology at the policy-making table. Different values and ideology may be assessed to determine which are more meritorious than others. There is significant opportunity for identifying ways and means by which to improve the application and influence of the social sciences knowledge to further inform the values and ideology discourses for policy making in both provinces.

It appears as if the social sciences have been ineffectual in making inroads at the policy table for several reasons. The policy-making community does not have the core competencies that allow them to effectively mediate between the empirical positivist data that they currently deal with and the postpositivist findings that may arise from a deeper problematization of the health care issues. Policy making is a redistributive process and the maintenance of the status quo is often easier than undertaking radical change that may have significant health improvements to a marginalized community with a weak voice. The social sciences have been late in developing and sharing an explicit means by which policy makers could differentiate with confidence high-quality social science from low-quality social science. This issue arises in part from the debate within the social sciences in which unrelenting relativism on the one hand and absolutism on the other has paralyzed progress. Significant progress has been made, however, in the development of criteria for adjudication on the quality of research in most areas and these, although continually debated and refined, do serve as a proxy of quality. The challenge in the future will be to facilitate an increasing capability on the part of policy makers to avail themselves of ethnographic studies, political studies, and ethical analysis.

One of the barriers to the effective use of knowledge by the policy community is explained in part by the fact that each of the epistemic communities uses and communicates in different forms of embodied, practical, and discursive knowledge. The practical knowledge of each of them is as different as it could be. Politicians think, communicate, and act in strategic and pragmatic ways. Researchers, on the other hand, are focused on the task at hand, eliminating as many confounding variables from an analysis as possible, and they speak in highly complex language. It is not a surprise that much of the time neither hears what the other side is saying and more frequently, as in the case with Alberta, impugn a motive to the other party that is less than cordial. The challenge is therefore to identify means and mechanisms by which the communication gap can be closed.

Another characteristic of the forms of knowledge that have an implication for the relationship between politicians and researchers is the respective function they fulfill in society. Politicians are elected and maintain their jobs because of their popularity in soliciting the support of their constituency. Researchers, on the other hand, are not driven by the motive of popularity; their motive is the pursuit of knowledge. Researchers undertake to resolve the paradox that arises when competing and constraining contradictions in society require them to say some unpopular things about how society should be organized or managed. The fundamental responsibility to articulate a challenge function is often perceived as a criticism or threat by the politician or government in power. Often these criticisms arise from the syncretic process and become a major barrier between the research community and the politicians. It is ironic that a healthy challenge function, which is necessary for a vibrant democracy, can become so divisive.

Policy makers and citizen elites are not as fixated by the extreme dichotomy of positions experienced by politicians and researchers. Policy makers in Alberta and Saskatchewan find themselves in the position of acting as bridges, often mediating between the research evidence and the policy decisions. Citizen elites whose role it is to protect the public interest are very aware of the respective posturing of the other two communities but are often helpless to advance a course because of the ideational and institutional interests that are being protected.

Regardless of which epistemic community is examined, practice is prime. Since practice is so fundamentally embodied in being a politician, policy maker, researcher, or citizen elite, the question arises as to what kind of practice they ought to undertake. Differentiating between a poor, good, acceptable, or best practice is likely to be contested territory regardless of which epistemic community one is a part of. There is likely great diversity in what may be deemed best practice, so undoubtedly there will be some characteristics of practice for each of the communities that can be rated as more meritorious than others. In the case of health care policy making, we are dealing with something that human beings hold in very high regard: their health. The good health of individuals is something the state benefits from and at the same time citizens value for its own sake. Health is an ideal concept and difficult to define, but its absence is undeniably something everyone would prefer to avoid for as long as possible. Based on this logic, best practice in health care policy making is not something that is an option. It should be expected, despite the observations of politicians and policy makers that it is neither necessary nor possible. The challenge is in the details of how it should be defined, although several academics have set their minds to helping develop best practice in policy making, from both the perspective of process and the substance of the matter.

We do not know whether using best evidence from the health systems sciences and social sciences to inform health- policy making results in better policy or not. This is, as one academic stated, something that is presumed rather than proven. What HQE appears to do is to provide a broader spectrum of experiences and validated concepts. This does not make policy making easier. It in fact makes it harder because there are more options to choose from and alternatives to develop. In addition, the messages derived from different forms of evidence may well be divergent, and choosing a course of action may be less obvious. This increased complexity in policy making requires an increased competence on the part of policy makers, on the one hand, and the increased trust of politicians in the process on the other. Policy makers in Saskatchewan were not as skeptical as those in Alberta as to whether best practices could be successfully launched in the bureaucracy. This may be due to the more established practice in Saskatchewan of using high-quality academic and research advice to inform health reform in the province, for example, Tommy Douglas bringing Dr. Mott and Dr. Roemer to Saskatchewan from the United States to help inform policy development for health reform (Taylor, 1978, p. 251).

Several reasons were identified in the course of the readings and interviews as to why best knowledge was often so recalcitrant in policy making. In some cases, the research has not been done and so the evidence does not exist. This is particularly true in the social sciences, which have not had the opportunity to be as actively engaged in producing primary research findings to inform health care policy making. Managerial competence in many cases has not been adequately developed to know how to access or assess the plethora of knowledge that may already be available. This was attributed in both provinces to the downsizing that took place in the 1990s as both provinces tackled the challenge of cost containment. Unlike the evidence-based clinical practice movement, which has a number of champions on the international stage and has made significant strides in the provider side of health care, there are few champions that have come forward in the health policy environment. This may be partly explained by how difficult it is to initiate change in institutions.

Another barrier between the research community and the policy-making community is the perceptions they have of one another. Policy makers think of research as something to be picked off the shelf when, in fact, it is more akin to a process. Policy makers, politicians, and researchers use different logics. Policy makers use the logic of arriving at sensible decisions, politicians at pragmatic decisions, and researchers at rational decisions. These logics may often be at odds with one another. Inherent in the social structure of democracy and research are different incentive structures that cause the members of the communities to behave in mutually exclusive and unsupportive roles to one another. Finally, they often must communicate to different audiences and are unprepared to adequately address one another's time pressures. These explanations were resonant with the politicians and policy makers in both provinces but somewhat more so in Alberta. In Saskatchewan, the policy making and health research functions appeared to be more consonant in their respective activities and the ends toward which the research was used. One possible reason for a closer alignment between the research and policy communities in Saskatchewan is that there appeared to be more trust between the communities. Saskatchewan citizen elites, and researchers in both provinces, were in agreement that improved connections and alignments were necessary.

Several researchers have demonstrated the complexity of knowledge utilization in policy making. One body of work illustrates six models of knowledge utilization (Hanney et al., 2003). The models are not mutually exclusive or exhaustive; they provide an appreciation for the fact that there is unlikely one approach that will work in all situations. The fact that there can be such diversity in how knowledge is brought in to inform health policy making does suggest that tremendous variation in effectiveness is the result. It does seem clear from the deliberative democracy literature (Cohen, 1999a); (Cunningham, 2002) that providing an environment where debates among the contenders can be held in an open forum in the pursuit of core values is more likely to arrive at a satisfactory solution than if it is done behind closed doors. The process has been shown to support facts and values that have merit over those that may be wrong or frivolous. Publicly discrediting ideas that are nonstarters but continuing to return to the policy table (e.g., the introduction of user fees) can be dispensed with quickly in these kinds of settings even though vested interests may be in favour of them.

The CHSRF has taken a strong leadership position in Canada to encourage the use of best knowledge to inform decision and policy making in health care. Initiatives such as providing and encouraging the opportunity for the interaction of researchers and policy makers, publishing best practice in knowledge translation, supporting and awarding research grants in knowledge transfer, and developing the skills of knowledge brokers appear to be steps in the right direction.

The literature (Lomas, 1990) points out the formidable complexity (Lavis et al., 2001) associated with the use of best knowledge (Lehoux et al., 2004) in health care policy making (Lewis, Saulneir, & Renaud, 2000). This fact alone reinforces the need to identify mechanisms and processes by which this can be achieved.

Review of ideologies and values

This thesis has argued that one of the weaknesses of the current health-policy-making process is that it often excludes the values and ideology entering the discussion in an open, transparent, and explicit way. Values and ideology are intractably linked and a part of the facts that are brought into the discussion, but they are often not explicitly noted and interrogated. Like scientific evidence, which can be of high or low quality, so, too, can values and ideology be of high or low quality and, for theorists of deliberative democracy, open to reasonable negotiation and reevaluation and not fixed preferences. People are allowed to hold their own values, ideology, and opinions, just as they are permitted to hold their own facts. If they are sharing the facts publicly, they are expected to have them right or reasonably right. The same is the case with values – they should accurately represent or reflect the values of the community. It is beyond the scope of this study to identify what the community values ought to be. At one time the fact-value distinction held such that policy making should deal only with facts, not values. What is clear today, at least in postpositivist minds, is that values are implicitly embedded in the facts and cannot be separated from them. If values are to be at the policy table, they should be there openly.

Because health or the absence of disease is such a highly considered aspect of human life, it would seem unusual that citizens would wish the potential state of their health to be influenced by a government that was not vigilant in its custodianship of the population health. The United States, where health is seen as a market commodity, differs from Canada, where it is considered a public good (Peters, 1995). To be duly diligent in the execution of its responsibility, the democratic pluralistic state would wish to ensure that the values and ideology dictating the health care policy-making process and substance had the population's health in mind. Although insufficient in itself, this process could be enhanced if the discourse surrounding the evidence on values and ideology were more open, transparent, and explicit.

Ideology is a powerful concept because often it not only helps to identify the problems and issues to be examined in a policy question, but also identifies the alternatives that will be considered as solutions. Postpositivism is a useful strategic approach in attempting to define a problem statement because it facilitates democratic ideals to be explicated, whereas a positivistic approach will provide empirical data but will not necessarily facilitate an understanding of the underlying causes of health care issues. The approaches and techniques of policy archaeology (Scheurich, 1994) and problemization (Davidson, 1999; Osborne, 1998) were useful in this study for this reason. Another simplistic tool for facilitating dialogue on ideology was the plotting of ideological positions on a grid as developed by Gibbins and Youngman (1996). This open expression of ideological positioning is helpful in allowing individuals with differing value perspectives to see their viewpoint expressed relative to others and to enter into discourse and assess the soundness of their judgment and arguments in relation to others.

Health care policy making is redistributive and by virtue of this character produces winners and losers. Policy making is not value neutral. How should the debate on the winners and losers be deliberated? The Canada Health Act defines the entitlements of Canadians to health care: health care must be universal, accessible, portable, comprehensive, and publicly administered. Since Canada comprises 13 separate and equal political jurisdictions, it is unlikely that a consensus can be reached on these matters without a national discussion and consensus building on the solution. The Health Council of Canada, which was formed as a result of the Romanow Commission, would appear to be one way to reflexively adjudicate in such a manner on a standard and consistent application of the Canada Health Act. Adjudication could take place around (a) facts, (b) facts and values, (c) means to achieve consensus, or (d) disagreement leading to reflexive deliberation.

Values, like ideology, can also be recalcitrant in health care policy making. The Romanow Report was the first national commission to highlight the importance of values in health care policy making. Romanow stated that the health system should be evidence based but values driven. How are we to get a handle on values to help inform health policy making? Science is of little help on this account. The "moral" or social sciences through sociology, philosophy, political science, and ethics can be disciplines that bring this kind of evidence to the policy-making discussion. The social sciences can be very helpful in explicating the values of individuals, communities, and society generally. Giacomini et al. (2001) developed a practical tool for differentiating between embedded and instrumental values, as well as ideal values. The bringing of values into the policy discussion permits participants to challenge and debate the merits of the kind of values at play. By demanding facts to support evidence and values, we can judge for ourselves what is true and what those in dominant positions would like us to believe is true.

Feedback from the informants, particularly politicians, suggested that both Alberta and Saskatchewan may be prepared to undertake an experiment in deliberative democracy to help inform health care policy making. Politicians in both provinces expressed the desire and need to provide new mechanisms for gaining public involvement in setting health policy goals and directions for the health care system. Citizen elites in both provinces strongly encouraged finding ways to facilitate greater citizen understanding of the health care issues in the province, as well as encouraging their involvement in the policy-making process. Researchers in both provinces were very supportive of the idea. Policy makers in Saskatchewan who had experience of dealing directly with the citizens on the closure of the 52 hospitals felt that dealing directly with citizens' issues and concerns was essential.

Review of narratives

The selected narratives reviewed in chapter 6 were of a limited number but they represented a wide spectrum of the kinds of inquiry that takes place in health policy making. At one level, the narratives are representational, embodied in the social, historical, and political circumstances during the time they were written. On another level, they are investigating issues in health reform from a specific scientific, values, and ideological perspective. The narratives provide common-sense stories that allow participants to situate their smaller projects. On closer analysis, the objectives of the various narrative histories (see Table 17) could be characterized as supporting (a) knowledge seeking, (b) stimulation of health reform, (c) policy agenda setting, (d) tracking activity, or (e) advancement of an institutional or ideational interest. Those seeking knowledge were often situated in a university setting and seeking knowledge from a historical, political, sociological, or economic perspective. The critical health reformers were also situated in university settings, but their objective was to describe and study the power relations maintaining the existing structure.

The policy agenda setting narrative histories were written primarily by government-appointed commissions, task forces, and blue ribbon panels established to study the problems in the health care system. They contained a series of recommendations to government on how to remedy the current ailments of the health care system. Government was free to accept or reject the recommendations. If the government that appointed the review was still in power when the report was released, the recommendations were often accepted. In Alberta, the Rainbow Report was released in 1989 and was the result of the work conducted by Lou Hyndman and other members of the Premier's Commission on Health Care (Premier's Commission on Future Health Care for Albertans., 1989). The Hyndman Report resulted in the establishment of regional health authorities in the province. This report was followed by the Mazankowski Report released in 2001 (Premier's Advisory Council on Health for Albertans., 2001). The Mazankowski Report concluded that Alberta's health system was not sustainable unless government made major changes to how health services were funded and delivered. This is the report that defined the ideological difference between Alberta and Saskatchewan.

In Saskatchewan, the Saskatchewan Commission on Directions in Health Care delivered their report to the Conservative government of the province in 1990 (Government of Saskatchewan, 1990). The NDP were elected to government in 1991 and appointed a Commissioner, Ken Fyke, to produce a report on the state of the province's health care system. The report, unlike the report in Alberta that looked to costs and sustainability of the health care system, focused on how quality could be sustained (Commission on Medicare., 2001). The issues of sustaining quality versus costs have been defined as the ideological differences between the approaches in the two provinces in respect to health reform. Ironically, it is in Alberta that there are greater means for financial sustainability.

The narratives that tracked the activity in health reform did so to provide policy makers, managers, and researchers a common foundation to work with about the status of health reforms. The final category of narratives, advancing interests, comprised think tanks whose role it was to promote a certain ideology or value in the narrative creation. The audience for the narratives ranged from the general public to policy makers and intellectuals. The degree of bias or interpretive license depended on the objective of each study. Those intending to advance a specific interest tended to be selective in the evidence pulled in to support their case. What is of particular note is that many narratives are created with the intent of advancing the discourse on policy making and by attempting to provide a particular perspective themselves become embedded in the larger conversation in society. My study, by looking at the representational world (level 1) and the self-critical approach (level 2), attempts to provide a way forward that would improve the process of policy making in health care.

Review of best policy

When academics met to discuss policy opportunities for advancing the health reform agenda in Canada, they did so by identifying what they felt were appropriate policy interventions, expecting that these would be adopted and reform would be achieved. What was learned was that implementation was a greater challenge than had been expected. Provinces began to undertake different reform strategies, leaving the country with a patchwork quilt of health reform initiatives. Think tanks began to emerge in an attempt to encourage a neoliberal marketplace solution and the encouragement of private delivery of health care services. Saskatchewan, the birthplace of Medicare under Tommy Douglas's leadership, became the defender of the principles of Medicare, while Alberta came to be characterized as the promoter for a role for the private sector in health care delivery. Governmental reasoning for the positions arose from a long tradition of communitarianism in Saskatchewan, while in Alberta it was a commitment to individual choice for access to services. The resulting dynamics in Alberta appeared to lead to a schism between the wishes of the government and the policy makers who were unable to deliver evidence in support of private delivery of health care.

Best practice in policy making in Alberta can best be described as conflicted. Politicians were in favour of it but policy makers who were expected to carry it out were pessimistic that it was possible and were not sure it was necessary. Saskatchewan politicians and policy makers were more likely to be committed to best practice in policy making and supportive of its development in the health department. The literature on best practice in policy making from New Zealand and the United Kingdom provides assurance that some government jurisdictions are attempting and achieving some success in introducing processes for best practice in policy making. The primary suggestions from the literature (Office of Science and Technology, 2000) on how to encourage best practice in policy making (Tenbensel, 2004) are to provide policy-making staff with training and staff development support, to provide access to data and information, to expect ethical conduct, to respect privacy and confidentiality, and to encourage the performance of the challenge function.

Commentary on relationship between state and knowledge

The role of the state in managing knowledge in society is a contentious issue. In the case of health care, the neoliberal state has taken an active role in facilitating opportunities where it can provide evidence to the citizens and in seeing "knowledge" as instrumentally important. This importance is indicated through the accountability and performance measures movement. Since the relationship between health care delivery and health status is tenuous at best, the state, in the form of the national and provincial governments, has undertaken initiatives to provide evidence to the population that they are attempting to improve access to health care services through accountability initiatives, demonstrating indicators of performance on access to service and improvements in health care delivery.

All informants were in agreement that greater accountability to the public for health services delivery and subsequent implications for population health was important. The challenges associated with the indeterminacy between intervention and the results make this a difficult challenge. One way forward is for the provincial and federal governments to continue supporting the CIHI in partnership with Statistics Canada and their continued refinement of developing mechanisms and ways to report on the effectiveness and efficiency of the Canadian health care system. The CIHI can also continue to develop ways in which linkages between the social determinants of health and the population's health can be better understood. This information is valuable in identifying where society should be investing its resources in the future.

Emergence of the theory

In developing my theory, it was necessary to bridge the themes emerging from the literature and the data from the informants. I accomplished this task by identifying four concepts that emerged from the literature and data: "best practice," "linkage," "accommodation," and "traction." I constructed them into a theory or model, characterized metaphorically as a spinning top, in which the practices of the epistemic communities interact in a dynamic fashion to deal with evidence, values, ideologies, and opinions to influence the policy-making process toward improved health of the population. My approach differs from traditional approaches in that it moves away from focusing on the influence and transaction of interests (although they are present) to focus on the transaction of *ideas*. My model assumes that the policy-making process is advanced if the transaction of ideas is improved. My thesis argues that bringing ideas in the form of values, opinions, ideology, and research evidence to the policy table will improve the explicit nature of the policy-making process. Calling for an enlarged mentality rather than common interest expands the horizon for problem solving through discourse.

Following J.R. Hall's (1999) adjudication of forms of inquiry within a discipline, I argue that values can be brought to the policy discussion with the same degree of rigour as traditional scientific evidence. The improved ability to identify the underlying social and health issues arises from the application of the problematizing techniques developed by Osborne (1998) and Scheurich (1994). The postpositivist approach was used to complement the positivist evidence brought to the policy discussion. The merging of the approaches comes with endorsements from the works of J.R. Hall (1999) and Clemons and McBeth (2001). This is what J.R. Hall identifies as the third path. The third path can be more easily facilitated if tangible tools and frameworks can be provided. To this end, the work of T. Smith (1991) on the theory of social knowledge provides a platform from which to build a more detailed model, hereafter referred to as the STEEPLE model, which policy makers will be able to recognize and integrate into their practice. Lessons that have emerged from the knowledge transfer literature and its application to the practice and policy-making settings in health care inform the model.

The theory provides an approach that bridges the gaps identified by the epistemic communities in my research. The fundamental mission of my project was to develop a framework in which cultural and language barriers can be lowered and replaced with a language that encourages best practice, improved linkages and interaction, and improved accommodation resulting in traction (improved health) to citizens. If practice, as Archer (2000) says, is "prime," this is where our energies are best focused.

Justification for the model

Traditional scientific evidence is insufficient to inform policy making on its own. The complexity and contingency of social phenomena require new legitimate forms of knowledge from the social sciences to complement traditional scientific evidence. Knowledge from contested areas of the social sciences represented by positivist and postpositivist approaches needs to be brought to the policy-making table. Each of the epistemic communities represents a different culture, language, and perspective as a result of their socialization and they assess a health policy issue from their norm. Differing perspectives arrive at differing practices and, as we know from this model, practice is prime.

The model I developed will enable the epistemic communities to use a similar language in order that improvements in policy making can be achieved. From the study, I found that the common language and culture of each of the four epistemic communities aspired toward the same ends: (a) good practice, (b) meaningful linkages and interaction, (c) effective accommodation, and (d) publicly accountable traction. Knowledge creation has within its own domains, fields, and disciplines a representation that may be debated regarding what qualifies as legitimate knowledge within that entity. The continuum of the debate between relativism at one end (every person or each community has his own "truth") and absolutism at the other (there is one "Truth," and here it is), is an untenable scenario for pragmatically informing the policy-making process. Within each of the fields, however, guidelines, standards, and criteria have emerged to guide the knowledge community to differentiate between what is meritorious knowledge and what is not, providing guidance as to what in that field is a small *t* truth. These criteria are rarely static; they continue to be revisited and refined, but they do exist to guide practice.

An analogous scenario can be drawn for the policy-making field. There are debates as to whether best practice in policy making is possible or necessary. A tried and tested best practice in conducting delicate brain surgery with the artful skill of a surgeon is more likely to be successful than a trial-and-error approach without experience. By analogy, today's health care policy-making environment lacks a commitment to best practice.

This was evident from the feedback of the informants. The literature clearly defines this as an issue, but it unconsciously excuses it as a practical reality of policy making that cannot be changed and must be "worked around." The argument of my thesis is that health policy is too important to be left to the vagaries of spurious will or fractious accident and needs to make a commitment to best practice.

Words are easy to write, but translating them into practice is more difficult. My thesis provides a series of suggested best practices that can serve as a starting point for a dialogue on this very important topic. Suggestions for best practice in policy making, research, linkages, accommodation, and traction to initiate discussion are put forth in Appendix F. The consequences of not committing to a strategy of best practice are to perpetuate the stalemate in health care policy making and continued erosion in the confidence of the citizen, politician, and policy maker communities in health care policy making.

I provide tools for the practical and pragmatic application of the model, provide cautious reflections, and identify opportunities for future research in the final chapter. The thesis identifies the most practical characteristics of a model that responds to the challenges of policy making in a very complex setting. The model was constructed so that it could be easily understood and applied by politicians and policy makers.

Encouraging values to speak to traditional evidence

Table 29 illustrates the role that value judgments, empirical judgments, and practical judgments have played in the past. Value judgments were made implicitly, empirical judgments were mostly made explicitly, and practical judgments were made in combination, implicitly and explicitly. Policy is derived from the blend of values and knowledge. The model developed in my thesis proposes that best policy results when value, empirical, and practical judgments are made explicitly.

Table 29: Value, Empirical, and Practical Judgments: Past, Present, and Future

	VALUE JUDGMENTS	EMPIRICAL JUDGMENTS	PRACTICAL JUDGMENTS
Past and present	Implicit	Explicit	Mixed
Future	Explicit	Explicit	Explicit
	Best values	Best knowledge	Best policy

Best Values + Best Knowledge = Best Policy

One of the characteristics of values is that they can strongly influence how we treat the empirical evidence. It became obvious from my research that "cherry picking" of evidence to support one's point of view was not uncommon. This is called bias. There is bias in value judgments, empirical judgments, and practical judgments and this must be kept in mind at all times. Table 30 is not fully inclusive, but it provides a simple framework to help think about the different forms of bias that may impact on judgments, how they can be identified, and how they can be countered.

Table 30: Bias and Judgments

	VALUE JUDGMENTS	EMPIRICAL JUDGMENTS	PRACTICAL JUDGMENTS
Forms of bias	Stereotyping Fragmentation Cosmetic	Invisibility Imbalance Unreality Linguistic	Power and influence Publication Measurement Language Country
Identify bias	Character Isolation "Shiny" exterior	Absence Single view Unrealistic Metaphorical	Observation Representative Funnel plots Absence
How to counter bias	Exposit Inclusion Substantiation	Inclusion Multiple views Realism Plain language	Empirical facts and values Publish negative results Categorization Translation Inclusion

Note. Adapted from www.american.edu/sadker/curricularbias.htm (Sadker, 2005).

Each of the epistemic communities might wish to test their judgments against the forms of bias identified and apply the mechanisms noted to determine if it changes their perspective and judgment.

Meaningful interaction between and among the epistemic communities should be as open, explicit, and transparent as possible. Policy by its nature is redistributive, so some actors will want to protect interests, others to protect policy. Self-, professional, group, community, or societal interest must be accounted for during redistributive exercises. Traditional scientific knowledge has been privileged in this setting – social sciences must become equal partners in order to provide a voice and language for values in the policy-making process. Values, ideology, and opinions must be brought into the conversation so that context and relevance are improved. Empirical evidence can be right, wrong, or uncertain. Values can be good, bad, or indifferent. Ideology can be emancipatory, constraining, or indifferent. Opinions can be informed or uninformed. Tools can be used to exposit and locate the values and ideology of individuals, groups, community, or society during the policy-making process.

During the 1990s, solutions were initiated in response to problems that numerous studies in the 1970s and 1980s had identified in the health care system. Health reform became the order of the day and wide ranges of solutions were explored. In one instance, a debate was raised between Ottawa and Alberta in which Ottawa protected the integrity of the Canada Health Act and Alberta saw it as a barrier to innovation. Saskatchewan positioned itself firmly with Ottawa. Both provinces agreed on the ends of the Canada Health Act; where they disagreed was on how to do it – the means to the end. The Friends of Medicare on the one hand and the Fraser Institute on the other helped animate the issue further. Behind the Friends of Medicare were the health care unions and associations; behind the Fraser Institute was private business. What were purported on both accounts as solutions for the protection of the public interest were the cloaking of other interests.

The theory

The theory or model I developed in this study is based on four primary thrusts:

1. Best practice on the part of the research and policy-making communities
2. Effective linkage and interaction among the actors
3. Accommodation of traditional HQE with complementary evidence about values, ideology, and opinion in an explicit, open, and transparent way
4. Traction: the effective development, implementation, monitoring, reporting, and evaluation of meaningful results of policy directed toward the improvements of the health status of the population

This list is not exhaustive: there will be other important considerations. For example, resource limitation may also have an impact, but for the purpose of this theory, the element is recognized and manifested in a form within one or two of the earlier noted primary thrusts. I will review what is meant by each of the thrusts of the model in turn.

Best practice in research

Like the situation in health care delivery, the creation and application of research and evidence in health care policy making is a complex phenomenon. It helps to separate the different forms of research that may inform health care policy. The CPHI and the CIHI published a working paper (2002) entitled "Tools for Knowledge Exchange: Scanning Best Practices in Policy Research" as a way of beginning to facilitate a national discourse on best practices. Best practices in this context are strategies that, from the viewpoints of both receptors and producers of policy research, have consistently been effective in informing the development of policies and/or influencing public policy outcomes. Summarizing their findings, the CPHI states, "In discussions with both producers and receptors of policy research, the critical characteristics of best practices in policy research seemed to be related to quality and accessibility of products, planning and execution of projects and dissemination of results" (Canadian Population Health Initiative & Canadian Institute for Health Information, 2002, p. 8).

Developing a list of best practice for the research community to inform the policy-making process is a dangerous enterprise. It is bound to be wrong because something has been left out or something has been included that oversimplifies the subject and therefore creates a storm of protest from the researchers. The identification of potential best practices for research to inform health policy making is an articulation of the advice synthesized from the literature and from the informants in this study. Since no best practice is known to exist to inform the question in Alberta and Saskatchewan, this may be a good place to start the conversation.

This is not an attempt to list the quality criteria for judging the merit of research in each of the domains or disciplines that may be called in to provide policy advice. The consensus of international best practices surrounding those criteria will serve as the basis on which that research is to be judged. Another point to be noted is that adjudicating the merit of the evidence from within a discipline does not automatically translate into a relative merit in the broader policy context. In the broader context, the evidence must be debated along with other forms of evidence.

The first observation is that the health policy community should be prepared to invite and take into account a broader spectrum than the clinical and quantitative research that has informed it in the past. Politicians were concerned that researchers were not sensitive to public sentiment. Quantitative methods being supplemented with qualitative methods or mixed methods may be the best approach to represent the public sentiment. Opinion polling techniques, using citizen juries, and deliberative methods may be effective techniques. Policy makers tend to be comfortable with the use of quantitative methods in the form of epidemiological studies, cost-effectiveness analysis, or decision modeling. This familiarity is because they have undertaken some studies in these fields during their education. These fields have also been around long enough that standards of best practice have been developed and it is reasonably easy to differentiate HQE from poor-quality evidence.

There has been an appreciation in the policy-making and research communities that the qualitative tradition has been underutilized to inform policy making (Shortell, 1999, pp. 1083-1090). Qualitative and mixed methods have defined approaches with explicit criteria, allowing the creators and users of the research to assess its quality and providing the researchers with a framework that encourages standardization and consistency in the development and refinement of research design and application of methods (Seale, 1999, pp. 189-192). This iterative relationship of refining best practice in the qualitative techniques will increase policy makers' trust in the information.

The second observation is that there is not always HQE available to answer questions that arise in the policy field because of gaps in the research. The biomedical field has been advancing the research agenda on the clinical questions quite effectively; however, many questions remain to be answered. The CIHR (and its predecessor the Medical Research Council), the Saskatchewan Health Research Foundation (formed in 2003), and the AHFMR (formed in 1985) have been providing support to this field of primary research for several years. Support for HSR has, however, been marginal, both in terms of the use of the findings by administrators, policy makers, and practitioners and in the development of infrastructure and funding. On the national level, the CHSRF has taken an important step to remedy this deficiency, as have the CIHR Institute of Health Policy and Services Research and the Institute of Population and Public Health. At the provincial level, the AHFMR, through the Health Research Collaboration between AHFMR and Alberta Health and Wellness, has attempted to address this weakness but much remains to be done to provide a stronger critical mass of support for HSR to be successful at informing health policy in a timely and relevant way. Mechanisms and processes to effectively identify the priority research opportunities need to be further refined and a financial commitment must be made to support this applied research.

In addition to encouraging more primary research to answer questions, secondary research that includes systematic reviews, narrative reviews, critical reviews, state-of-the-science reviews, meta-analysis, and HTAs also needs to be undertaken to answer questions about the effectiveness of health care interventions and reforms. These methods are effective in answering the broader mezzo (health authority level) or macro (province-wide) questions, which are of particular interest to policy makers about the effectiveness and efficiency of health care services. The amount of primary and secondary HSR conducted is limited and needs to be expanded to fill the gaps in the health policy research literature, as well as at the policy table. The AHFMR Health

Research Agenda for Alberta identifies many of the opportunities and challenges that currently exist (Alberta Heritage Foundation for Medical Research, 2003). By identifying themes for future research, the health research agenda can be effective in attempting to bring together the health research community and the policy community.

Best practice in response to the gaps in the research would facilitate an effective linkage between researchers and the policy makers to ensure that researchers are aware of where there is the need for future research. Providing appropriate rewards and incentives to encourage this type of research would also be helpful. Gaps identified in secondary research findings should provide the feedstock for the primary research agenda. This involves both parties being familiar with and continually refining the health research agenda of the province.

The following are a description of the more salient characteristics or questions identified in the literature and by the informants as criteria that one would expect to find in the best practice of the research enterprise:

- Ensure that the research question has been adequately interrogated (problematized) by the researcher and the policy maker. Does it speak to the issue needing to be addressed? The policy maker may be unaware of the importance of arriving at a clear, concise, and focused research question and at the same time, the researcher may be unaware of the complexity associated with the local context or policy maker's or politician's conundrum. A constructive discourse between the researcher, politician, and policy maker through several iterations will help arrive at a better research question than if the parties assume they each know what the other means. It is often useful for the researcher and policy maker to discuss what they anticipate the results or findings of the research to be and how that might impact the policy-making process. Having the politician and policy maker take ownership of the results of the research activity before it is undertaken may be one way to increase the likelihood of traction of the policy. Researchers, on the other hand, need to be prepared to help frame the findings in a way that policy makers and politicians can use with their multiple audiences. Thinking these questions through at the beginning is more likely to result in a successful result for both parties.
- Is the research project collaborative, engaging the involvement of stakeholders and members of the public as appropriate?
- Is the method of the research appropriate for the policy question being asked? For an economist, solutions to policy questions are seen in economic terms. It is important to look at the research question carefully and assess the best discipline

or, more likely, disciplines that will help shed light on the question. Policy makers and politicians are familiar with cost-benefit, cost-effectiveness, and cost-utility studies. They are less familiar with ethnographies of the experience of a homebound elderly person waiting for a hip replacement. I often hear clients who are dissatisfied with a health care access issue say if only it was the politician's mother who was waiting for the hip replacement, the problem would be solved quickly. It seems odd that no one has thought about documenting and presenting the implications on quality of life of those who are waiting for hip replacement to complement the evidence at the policy table that describes the number of cases by age group and wait time.

- Is the research question linked to an existing body of knowledge or does it identify a gap in the literature? It may be that there is already a body of knowledge published in peer-reviewed periodicals that addresses the issue; these should be brought to bear on the research question being posed. Do not assume, however, that the knowledge will automatically fit into the local context – explore the local context to determine if the findings are appropriate. If knowledge exists in a different language and appears to have utility, find out if an English version is available; if it is not, negotiate with the producers of the evidence to translate it into English. If a gap in the knowledge base is identified, it should feed into the primary or secondary research agenda in the next competition for grants and awards of research.
- The research enterprise must be in substance and perception autonomous from the policy-making exercise. The research enterprise must, however, be adequately integrated into the lifeworld of the policy maker and politician so that the ensuing result is timely and relevant.
- Is the source of the research credible and reputable? One of the most often repeated requirements identified by politicians and policy makers of what characterized HQE was that it should originate from a credible source with a good reputation.
- Does the design and method of the research encourage processes that are transparent, explicit, and open? This should never compromise the privacy and confidentiality of citizens in society, but Ethics Review Boards have ample experience in ensuring that research projects do not compromise individual privacy.
- Is there adequate description of the approach for data collection and data analysis that would allow the reader to determine how systematic it was? What were the inclusion and exclusion criteria for the studies selected? Which were excluded and why?
- Was the systematic review conducted with criteria to critically appraise the quality of the primary studies brought in to inform it? Would the reader be able to replicate the study and reach the same conclusions or results? Do the results or findings have relevance for your context?
- Is the research appropriately contextualized, taking into account the values, ideology, and opinions that may bear on the question? Using qualitative methods to identify the context is one approach.

- Is the research effort pragmatically positioned with a clear understanding of the policy environment?
- Is the research provided to the policy maker in a timely fashion with appropriate follow-up? Is there an opportunity to provide added value to the enterprise through the effective dissemination of the research findings?
- Is the research communicated and presented in a way that will meet the needs of the policy maker and other relevant stakeholders? This question addresses the common barrier identified by informants that often the reports are too opaque to read or the results are equivocal. Often, findings may be equivocal and the results of research uncertain; however, communication of findings should be unequivocal.
- Have ethical issues been adequately considered? The ethical issues surrounding a research question are much more likely to be addressed today than they were in the past. Qualitative approaches from social ethics, political science, or philosophy can help elucidate ethical issues.
- Has the research been externally validated by peer review? Research that has not been externally peer reviewed may not be of as high quality as that which has been externally peer reviewed - a common principle in best practice. Peer review, however, does not guarantee high quality; although it is the best process developed to date that provides some objective assurance that the research is internally valid. In selecting peer reviewers, an attempt should be made to identify the most knowledgeable individuals in the subject area and with differing perspectives. A weakness of introducing a peer review process for HSR grants is that it may take at least a year from drafting a funding proposal to the beginning of the project. Another weakness of the peer review process is that it may perpetuate practical knowledge that has become outdated by using reviewers that are part of the "old boys' club."
- Has an opportunity been provided for the research findings to be presented in a forum where politicians and policy makers can engage in a discourse with the researcher about the findings? The benefit of this interchange is that it provides a setting in which doubts and concerns on the part of the politicians and policy makers can be expressed and the researcher can become familiar with their issues and respond to them. It also provides an opportunity to identify what issues might emerge from the sidelines that would "blind-side" a public official speaking to the policy.
- Encourage research that provides a challenge function to the status quo in respect to the health care issue being examined. There will be members in the respective epistemic communities who take exception to some forms of this evidence. The evidence may threaten the interest of other communities as a result of a redistributive impact. Rather than subterfuge the evidence, let it stand on its own merits and allow the process of discourse and exchange to run its course.
- Finally, a mechanism may need to be established that maps the impact of the research findings on the policy process. Were the research findings useful in informing the policy? Did it improve the health of the community? In an age of accountability and requirement for providing evidence of performance, it would

be wise to think about developing a framework for mapping the outcomes (if there are any) of the research on population health.

This is not meant to be an exhaustive list but a starting point for describing how adherence to best practice may help advance the research-to-policy-making agenda.

Weakness and limitations of the best practice in research

Best practices are not obvious nor are they arrived at without contested discourse. Making judgments and building consensus to arrive at and advance "best practice" in a field, be it in practice or research, is "heavy lifting." One of the first weaknesses of a best practice is that it may stifle creativity and ingenuity from arising in response to a policy issue. A best practice must be able to tolerate some amount of creativity to be exercised in policy research projects. This can be achieved by leaving some amount of budget available to support promising and innovative curiosity-driven research. This curiosity-driven research should be encouraged from the existing disciplines as well as multi-, inter-, and trans-disciplinary approaches and emerging fields.

A second weakness of a best practices approach is that if it is not maintained in a dynamic way, it very quickly becomes outdated and falls out of favour as a guide for action. This is one reason that best practice has in the past had a bad name. The remedy for this is not thinking of best practice as having reached a destination once drafted and agreed to by the researcher community and the policy community, but as a point of departure to continually revisit it and challenge the assumptions, principles, and guidelines behind it. One way forward on this challenge is to participate in international forums in which the disciplines and fields meet to discuss methodological and substantive issues. The coming together of the research and policy communities at these forums would help build an improved understanding between them.

A third weakness of best practice is that it privileges those practices that have been around for years and have developed sophisticated methods, processes, and mechanisms that make them powerful explanatory and interpretative tools. There is no shortcut for facilitating the arrival of new forms of inquiry to the policy table. One way might be to hold an annual conference, inviting the epistemic communities to hear and discuss presentations of promising research findings, methods, or fields that are emerging.

Politicians and policy makers are generally resistant to the concept of best practice, yet none would disagree that it is a desirable objective to work toward. In order to improve the likelihood that best practice is considered for introduction within a bureaucracy, I developed a series of best practices for research in health policy making along four dimensions: structure, process, outputs, and outcomes. Structure represents the tangible characteristics of an organization, for example, its policies, financial resources, and staff. Process represents the functions or activities that the organization undertakes to achieve its mandate. Outputs are the results of activities in the form of reports, legislation, or regulations. Outcomes take a longer view and focus on the impact on the clients or population that the organization is meant to serve, in this case, the health of citizens, organization performance, and population health.

The best practices are identified in Tables 33 to 36, contained in Appendix F, and should not be considered definitive or exclusive; they are dimensions selected because they provide a comprehensive approach to organization design and are a starting point for the conversation. The best practices, as mentioned earlier, were derived from the literature and suggestions from the informants. The intent is that a unit within the health department would conduct an annual audit of its degree of compliance with the best practice. If it complied with the best practice, it would be marked with a "C." If it was a weakness, it would be marked with an "O," indicating opportunity for improvement. If it was not applicable, it would be marked with an "N." The results would be tallied and used to identify areas to concentrate on in the future.

Best practice in policy making

Unlike experimental and quasi-experimental research that has methods clearly articulated and in a continual process of refinement, the methods of policy making are not so clearly explicated. What is good health policy making as compared with bad health policy making? Can we define it? What criteria will we use to judge it? Can we observe and measure to see if we have achieved it? Has it made a difference on the health of the population? In the interviews, one senior bureaucrat declared that best practice in policy making was not only impossible, but also not desirable.

Scientific research is based on the objective observation of phenomena in order to disprove a hypothesis. The truth is rarely obvious - it emerges from a contested arena of claims and counterclaims. Good health science versus bad health science, although a contested territory, is rooted out with continual improvement of technique in the effort to seek the truth. Pharmaceutical companies have a proclivity (bias) to publish only the positive results of clinical trials for fear of the impact of bad news on sales and shareholders. This is an example of good business strategy but of bad science. Public criticism is causing pharmaceutical companies to rethink their practice because public confidence is eroding. Publishing negative results is good science. Being open with negative findings manifests the sense that the pharmaceutical company is acting in the broader public interest. Good science emerges from an increased public awareness and debate surrounding research design, methodological reasoning, and the findings leading to sound conclusions. There is an inherent conflict that emerges in health care policy making from the competing objectives of market interests in society versus the broader interests of the public good. Sound scientific methods are not a guarantee of good science, but they do increase its chances. Sound policy making that is based on sound science is more likely to have positive results for the health of a population.

The adoption of best practices in health care policy is sensitive to the societal interests of bureaucrats and politicians who wish to have more control over the policy-making process. This thesis has argued that adopting best practices is an important step in protecting it from the vagaries and influences of spurious interests. In the current situation, privileged interest groups may have an iron grip on certain elements of reform on the health care system – primary care reform. Opening the policy-making process up to the public and inviting qualitative forms of evidence to inform the question may help accelerate what is a painstakingly slow process at the moment. This may also help ameliorate the concern of bureaucratic managerial entities who are protecting their self-interest.

Scientific technique can be improved through repetition and refinement. By definition, an art or craft (practical knowledge) is difficult to improve through technique – this is what the senior bureaucrat was getting at by saying it was impossible. Policy making, as witnessed in the examples from our informants, touches on politically sensitive issues that can have serious consequences for the actors. The tension between doing what is popular versus doing what is right is classic. The model proposed in my thesis endeavours to reconcile this conflict, creating a health-policy-making space where best practice in scientific research and policy making can interact, improving the chance that outcomes may result in an improved health care status for citizens. I would like to move the discourse from "speaking truth to power" to "cooperatively and openly seeking the truth for improved population health." Pal (2001) provides a way forward separating the policy development function from the decision-making function. Decision making and choosing of options is a political process and taken by the institutional apparatus from the cabinet to the legislature (Pal, 2001, p. 341).

The evidence-based practice movement started in clinical practice and moved to EBDM during the 1990s. Today the pressure for evidence-based policy making is picking up momentum. To be successful, the evidence-based movement must infuse into the multiple levels of the health care system: practice, management decision making, policy making, and government. The application of best practice at all levels of the health care system that are mutually supportive of one another will likely have the greatest impact.

What are best practices in policy making? The following best practices are based on the feedback from the informants; the literature, particularly Pal (2001) and Seale (1999); and my insights from experience in the policy-making process.

- For policy staff to effectively integrate emerging research findings from the health policy arena into the policy agenda setting, development, design, implementation, and evaluation processes require the staff to stay current in the developments in those areas through training and education. There are currently no agreed upon professional core competencies identified for the practice of health care policy making in Canada. Core competencies for health care policy makers need to be developed, validated, and introduced to ensure a consistent standard of practice.
- Having access to data (in its many forms), a library, and competent information specialists who are familiar with the multitude of resources is essential.

Knowledge management skills and competencies are necessary so that available information can be harnessed effectively.

- Best practice in policy work keeps an open mind to the kind of evidence that should be brought in to inform the question. The social sciences are underutilized.
- Good policy work requires that quick responses be provided to immediate issues and that emerging issues be anticipated so that they can be responded to promptly. Policy makers often need to balance the quality of research they are seeking with the amount of time needed to create it. This is a risk management activity. Researchers, on the other hand, balance the quality of the research against the time they are given. How much risk is a policy maker willing to take? How much quality is the researcher willing to sacrifice?
- Maintain an honest and rigorous approach to dealing with issues, as they will continually test one's professional standards. Policy makers ought to have thought through their code of practice to prepare them for dealing with issues in which political expediency comes into play. Organizations may develop policies on confidentiality and privacy. Policy development is at the nexus of the political world and of analytical research. This can make it difficult to define the boundaries of politics, social science, and the health sciences.
- Maintaining confidentiality is an important attribute of policy making; however, it must be balanced against the requirement for transparency and openness.
- Democracy is founded on the principle that it is strongest when it is challenged and provides the opportunity for open and spirited debate on issues. Politicians and policy makers should encourage a strong challenge function to encourage debate on policy issues. This debate may ensure that the policy options are tested through the limitations and unanticipated design flaws and that responses are developed before they become apparent during implementation.
- Policy actions should be evaluated and examined as to what impact they had. Did they achieve the objectives they sought to address in improving the health status of the population? Was there traction of the policy?

This is not intended to be an exhaustive or exclusive list of best practices for policy making but a starting point developed from what was identified during the course of my research. Unlike the best practice for research, best practice for policy making in health care is underdeveloped and should become a priority of government over the next several decades (Davies, 2004). The model developed in this project is but one way forward.

Weakness and limitations of best practice in policy making

The primary weakness of undertaking a best practice initiative in the health-policy-making settings is that few believe that it needs or should be done. The fact that it has been introduced with some success and is gaining momentum in the public service in the

United Kingdom would suggest that it is worth pursuing (Office of Science and Technology, 2000). A second weakness is that best practice in policy making will likely need to be developed at such a high level of abstraction that it will provide little tangible guidance to the day-to-day activities of policy makers. It will only be through the introduction of new practices in response to the general guidelines that best practices will emerge. A third weakness is that there currently does not exist in Alberta or Saskatchewan a graduate program that focuses on developing professionally trained and credentialed health care policy makers. To deliver a program to develop, stimulate, and sustain core competencies with the breadth of knowledge needed for health care policy makers would take a sizable commitment of resources. A fourth limitation of the development of best practices is that they may not be used because of cynicism or lack of commitment from senior bureaucrats. This weakness will require some careful structural and process organization redesign to ensure that there are not perverse incentives that discourage best practice and to identify and introduce incentives to encourage it. A fifth weakness or limitation is that, like best practice in the research enterprise, it would become stale without continual improvement and refinement. This will entail a commitment on the part of government to update and refine the best practices in line with emerging consensus of best practice on the international stage.

Best practices were developed and included in Appendix F for the policy-making community to review their activities along four dimensions: structure, process, output, and outcome. These again are identified as a starting point for discussion about introducing best practice into the health care policy or decision-making settings.

Linkage

The second thrust emerging from the literature and data is the need to build effective and embedded relationships that facilitate a communicative and interactive infrastructure for strategic action among the epistemic communities involved in health care policy making. The old approach is no longer adequate or appropriate. My thesis seeks to provide a way forward by identifying linkages that are necessary for effective utilization of HSR in policy making.

Several politicians were critical of the research community for being separated from the "real world" in their "ivory towers" and lacking an appreciation for practical complexity. Some researchers were cynical about the apparent political expediency of politicians and those who did not appear to be acting in the public interest. Policy makers appeared to be caught between the two "cultures" of the politician and the researcher. It is therefore not surprising that policy makers had difficulty facilitating effective linkages between the politicians, researchers, and citizens. Informants made reference to the need for effective interactions and for them to be embedded in the institutional structures and relationships, the reason this characteristic emerged as the second thrust for the model.

Politicians, particularly in Alberta, felt that it was important that researchers have an appreciation of the role and responsibility that a politician must undertake. One politician suggested that those in the research community would have a far better understanding of the broad spectrum of challenges facing politicians in their role if they had the opportunity to work more closely with them. On the other hand, researchers felt that politicians could gain significant insights by having academics make presentations or speak to issues that were of currency in the health care system. One of the politicians gave an example of a set of sessions that were delivered in Edmonton by academics from the University of Alberta on contemporary challenges in Alberta society. This kind of interchange was seen to be very beneficial and appreciated by both parties. Another suggestion was to have politicians involved in the development of a social science research project from problem identification to conclusion. Having each of the actors – politicians and researchers – better appreciate the other's role and responsibility was seen as a way to encourage progress on this front.

One of the important linkages identified between the policy maker and researcher community was the opportunity for the two parties to sit down and clearly articulate and interrogate the problem or issue to be researched. In some cases, policy makers or politicians are under the impression that the research to answer a particular issue is available somewhere – it is a matter of finding it. What is much more often the case is that the context or detail of the research does not match the way the question is being framed locally. One response to this is to have the policy maker and the researcher spend adequate time being certain that they have fully interrogated the question. This may involve the researcher doing some work after the initial conversation and bringing back preliminary feedback of what the state of knowledge on the topic appears to say and to use this information to further refine the question. This iterative process of refining the problem statement has been found to be very useful by the informants to ensure that the question being asked is the correct one.

One of the critiques identified in the informant interviews is that research may be very accurate in taking into account the empirical evidence in terms of some information, but it does a poor job of dealing with issues surrounding values. Interviewees, particularly politicians, felt a major shortcoming in the research conducted was that researchers did not have an appreciation for the public opinion and values surrounding the issue being researched. Details about how to effectively link or integrate values and opinion into HQE will be discussed in more detail in the section on accommodation. As one informant pointed out, *"Evidence must speak to the values and the values to the evidence."*

The observation was made that in some cases it appears as if politicians, policy makers, researchers, and citizen elites are in conflict with one another about an issue. However, if the issue is disentangled, what frequently appears to happen is the identification of other interests that have become entangled in the process. The detracting issues have been inserted in the discourse, giving the appearance that they are central to the debate, when in fact they are not. The Saskatchewan politicians who were faced with having to close or convert 52 rural hospitals in Saskatchewan provide the best example of this. In many cases, when asked about the ends of health care for their community, people agreed that what they wanted was access to high-quality health care. However, in public meetings held in communities to discuss the closure of their hospital, the citizens would be emphatic that they did not want their hospital closed. A citizen informant, however, stated that when he was in a casual conversation with a community member following a public meeting and asked when the last time was that they had a family member in the hospital, the response was a look of surprise by the individual who stated, *"Are you kidding I wouldn't bring my dog to this hospital."* The response exemplifies a not infrequent situation that arises in which what people say is really intended to protect a source of economic activity, employment, or reputation in their community and not access to health care. There is a great deal of insecurity associated with one of the members of a rural family losing his or her job because of a hospital closing. On the prairies, a second income is often necessary to keep a farming operation viable. As one politician pointed out, in circumstances such as this, it is necessary to deal with the basic insecurity introduced in the community as a result of some of these actions; some middle ground, such as converting the hospital to a health care centre, may be more appropriate in the short term. HQE might suggest that all hospitals in Saskatchewan be closed, except for those in Regina and Saskatoon, to improve the health status of the province; however, our choice to value rural life has us take a more moderate approach.

One of the politicians coined the phrase that for evidence to be useful in policy making it must be *"translated into relevance."* What does it mean to my immediate community setting? The challenge is often not that the research is not worthy, but rather, those listening to the message do not understand what is being communicated. For linkages to be effective among politicians, policy makers, citizens, and researchers, the information must be communicated in a way that is going to make sense for the respective parties. One of the approaches that is recommended to respond to this is the 1:3:25 rule that has been developed by the CHSRF. In this approach, every 25-page research report should start with 1 page of main messages and be followed by a 3-page executive summary. The findings of the research should then be presented in no more than 25 pages in a language that a bright, educated person – not only a research-trained person – would understand (Canadian Health Services Research Foundation, 2003).

One suggestion made by a policy maker and repeated by several other informants was the power of using a pilot or demonstration project to build linkages of understanding among the actors. There are a number of innovative ideas that have been shown to work in other jurisdictions and there may be a reluctance to try them in local settings because they are *"different from the way we have always done it"* or it may introduce a new form of financial arrangement to pay for the services. A pilot or demonstration project would test and validate the appropriateness of the approach. This is often a nonthreatening means by which all of the actors can provide input as to how the project should be implemented and evaluated. The journey of participating in such an effort is often found to be rewarding as well.

An important barrier to effective linkages between the policy-making and research communities is the respective reward and incentive systems in place. Researchers are often reluctant to undertake contract research projects on behalf of policy makers because (a) their scientific autonomy may be compromised, (b) there is an inadequate amount of time allotted to do an "adequate" job on the project, (c) there is inadequate financial remuneration for the project, (d) the policy maker will not permit the researcher to publish the findings, (e) one branch of the government will not release the information that another branch has requested the researcher to retrieve, or (f) adequate time is not permitted for external peer review of the study. Researchers in the university setting are encouraged to undertake as ambitious a research program as possible by winning external grant applications and publishing the results in high-quality peer review journals. The incentives for the research community in universities are not compatible with what policy makers can provide. Some realignment and opportunistic relationships of mutual benefit through incentives should be explored.

Best practice for linkages were developed and are contained in Tables 37 and 38 in Appendix F along the dimensions structure, process, output, and outcome. These again are identified as a starting point for discussion about introducing best practice into a health department.

Accommodation: The analytical model

Structurally, the development of best practice and linkages to facilitate improved policy making is only half of the story. Politicians, policy makers, and researchers need a mechanism or process where the open, explicit, and transparent discourse surrounding the scientific evidence, values, ideology, and opinions can be negotiated and transacted. This would take place within the third theme that emerged from the literature and data: accommodation. Accommodation is where the hard work of policy making will be done in the future. It is the point at which the conciliation of the positivist approach to policy making and the unavoidable tension that will result from the introduction of postpositivist strategies of problematizing the issues and looking to advance the population health agenda will take place. The "palace wars" so common in modern and postmodern methodological debates will see their reflection at the policy-making table in the future. The conciliation of the two traditions at this locus is what J.R. Hall (1999) describes as the third path.

Clemons and McBeth (2001) foreshadow the practical implications of attempting to reconcile the two traditions.

> Positivist approaches do not help to end the conflict that occurs over problem definition in policy making. Instead, positivism inserts a **hegemonic lifeworld** [bolded in original] view into the decision making process that stifles democracy. However, postpositivism seems to just confuse the issue of problem definition. It is more democratic, but does democracy mean anarchy? What is needed is a fusion of the tangible analytical skills provided by positivism with the democratic aspirations of postpositivism. What is needed is praxis. (Clemons et al., 2001. p. 181)

If practice is prime, we need best, good, or prime praxis in health care policy making. My model proposes a third path for policy making: accommodation as a mechanism of reconciling the evidence speaking to the values during policy making. The model responds to the exasperated response of the policy maker who indicated that best practice in health care policy making was neither possible nor desirable.

All four epistemic communities kept repeating that research findings often appeared to be "outside" of the reality in which politicians and policy makers function. This observation was recounted on several occasions and appears to be a primary barrier to an effective relationship between the policy-making community and the research community. The dissonance arising between the research and policy-making community can be partly explained by what Lyotard has described as a differend, "a cause of conflict, between (at least) two parties, that cannot be equitably resolved for lack of judgment applicable to both arguments" (Lyotard in Jary et al., 2000. p. 154). In a sense the parties are talking to one another, but there is no meaningful communication. Mutual understanding is impossible and conclusions are unreachable. The force of good reason is unavailable for reasoning issues. The lack of conciliation or taking into account of these other elements in the local context is hindering the uptake of HQE. Keeping with the spirit of being transparent, explicit, and open with the use of HQE to inform questions and issues of health care policy, it is recommended that politicians and policy makers ensure that the same degree of transparency and openness is applied to the opinions, ideology, and values circulating around the issues and that these be openly declared and considered within a broad accommodation of them with the HQE. The term *accommodation* derived from the word accommodate and is defined as a "means to adapt; harmonize; reconcile; settle differences between" (Sykes, 1987. p. 7). The principle behind accommodating conciliation between evidence, values, ideology, and opinions is to make them explicit and transparent and assess the veracity of them in relation to improving the health of citizens.

The mechanism or process of accommodation requires a broad framework as well as a pragmatic guideline to make it realistic to use. One comprehensive framework that may be appropriate was developed by T. Smith (1991), who examined the role of philosophical discourse in social theory with a view to answering two questions: "How are we to grasp social reality? How are we to transform social reality?" (Smith, 1991, p. 3). The answers to the first question are provided by social science. The answers to the second question are provided by social policy. Resource availability, as well as the influence of interests and values, restricts social policy. To mitigate these factors, T. Smith proposes integrating a third branch of social theory, social ethics. T. Smith subdivides each of the headings of his model into three more branches. His headings and branches are reproduced in Table 31.

Table 31: The Branches of Social Theory

Heading	Branch of Social Theory
A.	Social science 1. empirical research 2. empirical theories 3. empirical models
B.	Social ethics 1. value analysis 2. selection of normative principles 3. evaluations
C.	Social policy 1. normative models 2. strategies 3. tactics

Note. From T. (Smith, 1991).

T. Smith's (Smith, 1991, p. 4) nomenclature provides us with an inclusive and explicit checklist to guide the development of a practical approach to identifying the domains, fields, and disciplines in the social sciences that can be brought to bear on health policy issues. The STEEPLE model, derived from T. Smith's analytical model, is described in detail in chapter 12 and provides a means by which policy makers can identify ways to make more effective use of the social sciences to inform health policy issues.

T. Smith (1991) identifies the three forms of social science inquiry (a) empirical research, (b) empirical theories, and (c) empirical models as ways to understand how we are to grasp social reality. In respect to transforming reality, T. Smith identifies three forms of social policy: (a) normative models, (b) strategies, and (c) tactics. Living in the conditions and constraints of the lifeworld, we are governed by limitations of time and resources to achieve the ideal society. Through social policy, we establish long-term goals (ends) for our society and through the mediation of ideas, values, institutions, and interests, we have to make choices as to what strategies and tactics (means) we will pursue. Social ethics in the form of value analysis (embodied and instrumental), selection of normative (ideals) principles, and evaluations are activities that we can rely on to mitigate between what we aspire toward in social policy and what social sciences inform us is possible.

T. Smith's (1991) nomenclature cuts across the traditional scientific and social sciences disciplines that health care policy makers are most familiar with. Empirical research collects facts about society and requires a distinction between what is nature and what is social. A second distinction is that of what constitutes an entity in society. T. Smith provides a detailed description of the categorical-ontological, epistemological, and normative issues associated with each of the nine branches of the social theory. It is beyond the scope of this project to examine those in detail but the broad nomenclature will be used to identify seven social science disciplines (STEEPLE) that policy makers currently recognize and can use to advance the evidence brought to inform policy making (Smith, 1991).

The concept that T. Smith develops analytically can be represented metaphorically in a dynamic reflexive mode of policy development. The ends to which a society aspires and how well it does in relation to that is described in my thesis as traction.

Traction

The three elements of my model – best practice, linkage, and accommodation – are only effective if they result in the improvement of the health status of the citizens. Osborne (1998) warns us to "watch the movement of those things which once were necessities to sustain the health of citizens now become goods accessed for pleasure or through privilege" (Osborne, 1998, p. 186). For progress to be made, the first three elements must have "traction" in health care policy making. Traction is defined for the lay public as "the act of drawing: the state of being drawn; *also*: the force exerted in drawing" (Merriam Webster, 2005). I use an analogy of traction from the physical world and bring it to the social. Best practice in policy making and research with closer and meaningful linkages being achieved to accommodate the HQE with values, ideology, and opinion cannot be effective without some form of force (traction) moving it forward. Traction in my model is the way to achieve material (demonstrable or measurable) progress that results from the HQE, ideology, values, and opinion combining to move the health care reform agenda forward in the citizens' interests. How do we know when traction is achieved? When is it moving in the "right" direction?

The most basic manifestation of successful traction in a society would be the regular reporting of (morbidity and mortality) improvements in the health status of the citizens in a community. The CIHI has begun to post the results of national health surveys, as well as targeted health studies, on its Web site. The adjusted data, reflecting the mortality, morbidity, incidence, and prevalence of ill health in its broadest definition, begin to provide some objective measure of how we are doing as a society. The recent increase of selected illnesses in Canada because of the tainted blood in the Canadian blood system, contaminated water in the Battlefords, and the SARS outbreak are all examples of public health taking a step or two backward. The following excerpt from the *Statistical Report on the Health of Canadians* states:

> Canada's youth suicide rate has not recovered from its dramatic climb that began in the 1970s, and this country remains the exception in the OECD for having youth suicide rates above those of the general population; more than 45,000 deaths annually are attributable to smoking, and women are claiming an increasing share of these. (Canadian Institute for Health Information., 2003. p. 304)

Reducing the youth suicide rate or the death rate from smoking each year by a specific value could be an explicit way of establishing a priority for public policy and the determination of progress made by the government and citizens in improving those over time. This is, of course, a double-edged sword and one that governments are reluctant to undertake because if the proclaimed targets are not achieved (for whatever reason), this becomes fodder for the Opposition party at the next election to point out the inadequacy of the political party. The Offices of the Auditor General from across Canada have been, however, encouraging governments to be open and explicit about setting and monitoring these types of targets.

I have described what a positive or negative manifestation of traction in health policy would be, but how does one achieve it? This is the difficult part because our understanding of the causal linkage between state intervention in health care policy and resulting health status is very much in its infancy. The work of the United Nations in developing the Human Development Index is one example of an effort at measuring a country's move toward greater social justice and improved health. The Human Development Index is a composite of three elements of human development: life expectancy, level of education measured by a combination of adult literacy and mean years of schooling, and standard of living adjusted to local costs (United Nations Development Program., 2003). Continuing to refine these mechanisms of measuring the population health will be important in ensuring that we do not lose traction toward improved population health.

I have developed a series of best practice examples for traction and these are included in Appendix F (Tables 41 and 42) along the dimensions structure, process, output, and outcome. These again are identified as a starting point for discussion about introducing best practice into a health department or health authority.

Accommodation: The metaphorical model

The data from the interviews indicate that all informants are individually committed to serving and achieving the very best health status for the citizens in Alberta and Saskatchewan. It is also very clear that there are varying points of view as to the means that would best achieve this. The challenge is to develop a model that will help inform policy in health care, which will be focused on the end of ensuring accessible high-quality health care for the citizens, without compromising this end because of the contested terrain on how it is best achieved. In other words, the health status of the population should not be eroded or compromised as a result of ill-informed positions in ideology, values, or opinions trumping HQE. The objective should be to privilege a policy-making posture that acts to provide an appropriate balance between individual liberty, community welfare, and social justice. It is necessary to heed Osborne's (1998) warning of not taking a step backward as a society. We can think of the move toward improved social justice and higher social evolution in our society as being along a continuum in which the state, characterized as a spinning top, is influenced by opinions, values, ideology, and scientific evidence – all synthesized into HQE. Too much of one of the factors without a counterbalance from the others can very easily upset the spinning top or at least set it wobbling. An even advancement is achieved when all four elements, opinion, values, ideology, and HQE, are progressively informed of how best to move toward the value of a higher order of social justice. In the context of T. Smith's (1991) social theory model, social science, social ethics, and social policy all move toward increased enlightenment through the dynamic relationships reconciling the constraining and competitive contradictions that arise in the lifeworld.

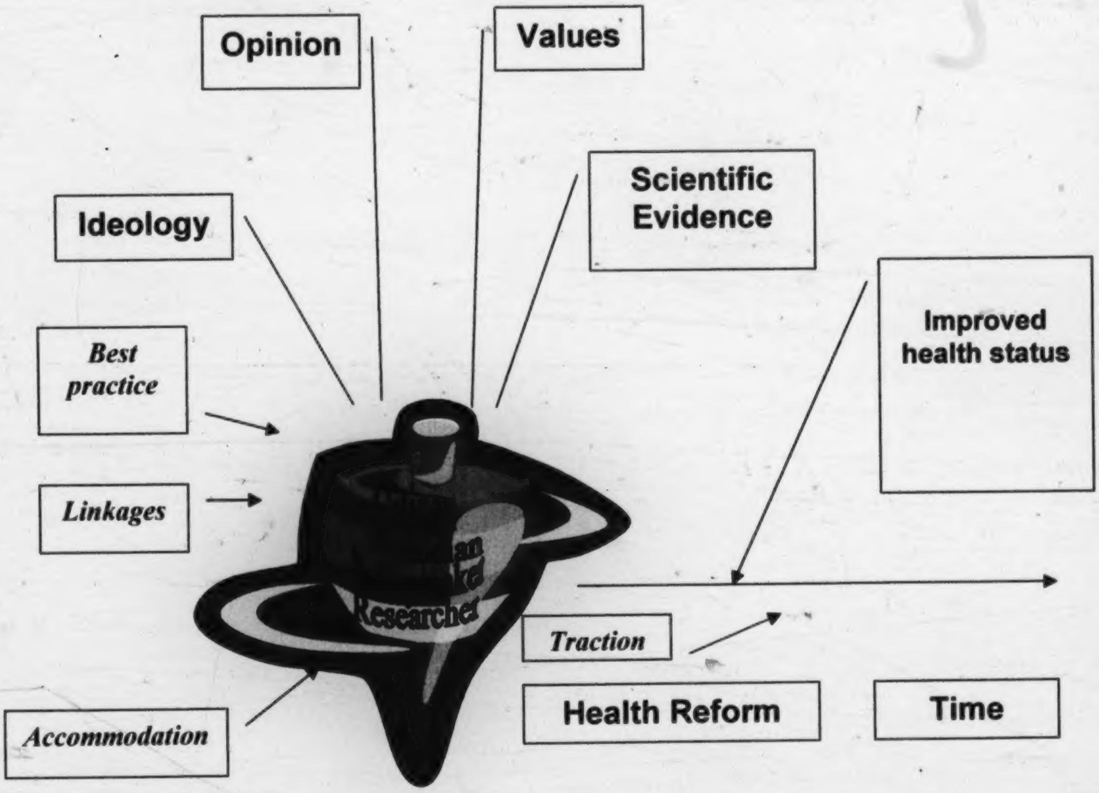
The model I derived is built on the following algorithm in which each of the elements is represented by the best-quality research from their respective domains. The values associated with a health intervention, for example, are informed through high-quality ethical studies whose merit is measured against the quality criteria of that field. Ideology is extracted from high-quality studies in political science that are measured against the criteria of the domain of political science. Where the issues may be contested because of the evidence, this information is made explicit and reconciled through consensus or arbitration. The newly formed Health Council of Canada may be appropriate to act as arbitrator on contentious health policy issues. Opinions of the public may be captured through high-quality opinion polling or surveys. Scientific evidence is brought to the policy table and the interchange between it, values, ideology, and opinions is facilitated in order to arrive at the health care policy.

High-Quality Evidence = Values + Ideology + Opinions + Scientific Evidence

How does this model avoid the continuation of embedded power structures that may not be supportive of health reform but rather wish to see the status quo maintained to preserve their privileged position? The answer lies in encouraging an effective process in arriving at HQE that is prepared to challenge the status quo by allowing marginalized voices to be heard. Adding the variable traction into the algorithm should result in the explicit monitoring and reporting of social policy in meeting the targeted improvements in population health status. Figure 7 illustrates my theory/model.

Best Practice (research and policy making) + Linkages + Accommodation + Traction =
Improved Health Status

Figure 7: Moving toward the value of improved health status through balanced health reform development.


Opinion
Values
Scientific Evidence
Ideology
Best practice
Linkages
Improved health status
Researcher
Traction
Health Reform
Time
Accommodation

Jary and Jary (2000) define politics as "the processes within a state or organization (including groups of all kinds, e.g. families) concerned with influencing the content and implementation of the goals, policies, etc., it pursues, its government" (Jary et al., 2000, p. 467). The informant interviews in section 3 of the thesis provide us with significant insights to describe the role of ideology, values, opinion, and HQE in Alberta and Saskatchewan, which attempt to influence the content and implementation of health care policy surrounding health reform. The model or theory developed in this project is an attempt to provide an explicit, open, and transparent way in which the processes of politics and policy making can take place with a view to maximizing the utilitarian end that everyone agrees with: that of maximizing the health status of citizens. To review, four thrusts are identified in the model.

1. Best practice – Are the actors performing their role to the highest internationally accepted standards of excellence in both research and policy making?
2. Linkage – Are the actors connected and interacting in a meaningful way?
3. Accommodation – Can we explicitly and openly reconcile the ideas, in the form of HQE, values, ideology, and opinion, on the basis that they respect individual liberty, community welfare, social justice, and democratic authority?
4. Traction – Are there means for moving the agenda forward and is there evidence of making progress on the population's health?

Interesting questions to pose are as follows: What does the endpoint of improved health status looks like? To what are we aspiring? How will we know when it is achieved? It appears as though the potential improvements to the human condition may be endless as each improvement in life expectancy, reduction in morbidity, and improvement in the quality of life can always be made a little bit better. The practical reality of this is that continuing improvements may be unrealistic as human improvements reach a plateau and the expenditure of resources results in no appreciable improvement in health status or, as in some cases, begins to have more negative effects than positive (iatrogenic effects). The challenge in the future may be to more equitably distribute the opportunity for good health to those who are marginalized in our society or who live in less advantaged countries. For example, the emergence of new technological gains in the form of robotic limbs, pharmaceuticals that sharpen thinking, or interventions for increasing human strength are being aggressively researched for application in warfare. Migration of these interventions to health care will start with those who can afford to purchase them. Will the marginalized, such as victims of thalidomide or those who have cerebral palsy, have state-sponsored access to these forms of human enhancement? Once the impaired have access to these forms of human enhancement, what is to prevent able-bodied people from wanting to enhance their cognitive and/or physical abilities? These questions cannot be answered by science alone – they require the knowledge of the social sciences and social ethics to be brought into the public policy conversation.

Knowing whether a society is making progress along these four thrusts requires that periodic critical evaluation take place to determine how well we are doing. Politicians are required to undergo this scrutiny every 4 to 5 years in a healthy democracy by their citizens. Mechanisms for reviewing the performance of the policy-making and research communities will need to be developed and applied critically. Caution will need to be taken to ensure that these evaluations are not pseudo-evaluations or opportunities for self-aggrandizement, political posturing, or profit taking. CIHI and Statistics Canada could become the national agencies that monitor the population health status of Canadians on a regular basis. The National Health Council could undertake the role of conducting a report card of how well we are doing on a national and annual basis. For these evaluations to be effective and credible, they must be carried out by internationally respected peers external to the process and they must maintain their independence.

This project characterizes explicitly the interplay of evidence, values, ideology, and opinions in health care reform policy making among the research, politician, policy maker, and citizen communities. The relationship of democratic authority of the state and the liberty of the citizen in the arena of individual and population health is complex and indeterminate. Complexity and indeterminacy should not be an excuse to not act. Social and political history has secured for us evidence of the delicate balance between the scientific enterprises on the one hand and progress of improved health status on the other. Examples of the scientific enterprise, such as Nazi experimentation in eugenics getting ahead of the moral enterprise, have resulted in unfortunate political and social interventions that diminish individual liberty and human dignity. The balance between the preservation of individual self-interest and community interest has also been demonstrated to contribute to a "paralysis" in making sensible policy when those interests are put ahead of the larger community interest. It is in the interest of the democratic state to have the authority and will to recognize when self- or group interest threatens further improvements in the population's health and it must be challenged.

Informants felt, and the scholarly literature confirms, that only by transparently, openly, and explicitly making the evidence, values, opinions, and ideology visible and part of the public debate can the "hostage taking of issues" and "interest group gridlock" be freed.

Pragmatic wisdom based on HQE is not enough to advance the health reform agenda in Alberta and Saskatchewan. Opinion, values, and ideology need to enter the debate explicitly and in a meaningful way through the social sciences. Informants all believe that HQE and sound reason and judgment should be exercised in deliberations to arrive at what would be the best health reform policy to improve the health of the population; however, HQE cannot do it alone. If it does try to go it alone, it risks being trumped by opinions, values, and ideology. There are a number of reflections, practical tools, and recommendations for future research that emanate from this work identified in the concluding chapter.

Chapter Twelve

Reflections on the model: Applications for policy making and recommendations for future research

Introduction

The first purpose of this chapter is to reflect on the theory or model of health care policy making that I developed in this project. The reflections will be oriented to looking at scenarios of opportunity for testing the model on the one hand and its limitations on the other. A second purpose is to identify a number of recommendations that may help to advance the agenda of effective health care policy making and further research. Reflection is important because it reminds the author and the reader that this is one approach to the problem that was articulated at the beginning of the thesis and strongly enforced by the informants. To repeat the research question for this project, "What was the interplay among evidence, values, ideology, and opinions during health reform in Alberta and Saskatchewan from 1987 to 2003, and how can this knowledge help inform politicians, policy makers, researchers, and citizens on how to improve the health care policy-making process in the future?" This work is not held up as a definitive response to the research question but rather as one way that the problem can be addressed and serves as a starting point for discussion among the politicians, policy makers, researchers, and citizen elites about how to advance the agenda of improved health care policy making in Alberta and Saskatchewan.

A second reflection worth noting is that all of the informants interviewed desired an improved future state in respect to health care policy making and an improved population health – no one was in favour of more ignorance or disease. The frustration from many informants was that there did not appear to be many effective mechanisms in government policy making to help facilitate a collaborative way (means) forward. The model developed here does provide a balanced approach to educating publics and policy makers around mechanisms for improved means for health care reform. Whether this approach has merit or works is for others to decide.

Best practice

The model in my thesis is built on the approach that Weber (Weber, 1947) used in establishing *ideal types* against which to compare and analyze the lifeworld. I have undertaken to establish a parallel concept of best practice in policy making and research, suggesting a way forward for improving health care policy making. Best practice may be thought of as an ideal type – something to aspire to and work toward. The primary limitation of an approach surrounding best practice is identifying and agreeing on what those best practices are. This is contested territory and an area that many demoralized policy makers feel is recalcitrant. The apparent impossibility of a task should not dissuade us from pursuing it if it is grounded on sound principles and if the possibility for practical gains is sufficiently evident. The analysis of the role and application of knowledge in society earlier in the thesis suggested that, between the garbage can theory and linear rationalism of policy making, there was plenty of room to create best practices.

There is already an effective mechanism (albeit contested on details) in place to adjudicate on the merits of government: the constitutional order of democratic election. The criteria for adjudicating best practices in policy making and research to inform policy making is to examine how well they are performing. Performance criteria could be derived in support of the stated objectives of the Canada Health Act, which are to provide Canadians with a health system that is publicly administered, comprehensive, universal, portable, and accessible. These criteria could be developed, implemented, and monitored by the national Health Council.

There are several limitations to this approach. The first is that with multiple actors, institutions, and interests at play, it may be very difficult in a democratic society to "legislate" improved access to services or improved quality of care. Access to services and quality of care takes place at the bedside, a distance away from the legislature, and there is no guarantee that policy actions will translate into improvements for the patient. The problem of attribution is therefore an important one to keep in mind. A second issue is captured by the phrase "the devil in the detail." It may be easy to say that the federal government should monitor the health status of the population, but in actual fact, meaningful indicators of individual health are difficult to ascertain beyond broad indicators of population health. These issues, however, can be overcome with appropriate sampling techniques. In spite of these challenges, the often repeated feedback from informants that research is not relevant, timely, or contextually sensitive cannot be ignored. One the other side, researchers feel unwelcome, unappreciated, and underutilized in respect to informing the health policy enterprise. Doing nothing in response to this dilemma is not an option if a viable alternative emerges on the policy horizon. This is reenforced by a strong expression from the informants and the literature that one way forward is to create a setting in which the traditional evidence can speak to the values, ideology, and opinions around the policy table. Articulation of the HQE on those variables can be achieved through the application of the social sciences in health care policy making.

An immediate weakness of introducing values, ideology, and opinions into the policy debate will be unfamiliarity with how to assess and apply the evidence. This will require in-service training and ramping up the skills of how this knowledge can be effectively integrated into the policy discussion. Attempting a few pilot projects around several policy issues that have complex dimensions associated with them will help policy makers gain confidence in using the practices.

Communities in discourse: Linkages and accommodation

The responsibility for health care delivery in Canada is a provincial jurisdiction. The provinces will be at varying states of preparedness in respect to the introduction of best practices, linkages, and accommodation. Saskatchewan has taken the lead in Canada by beginning to develop best practices, forge linkages, and introduce processes of accommodation for improving health care practice, delivery, and policy making through the introduction of the Health Quality Council to serve their health care system. The mandate of the Health Quality Council is to do the following:

- Develop evidence-based standards in health care delivery. This will include providing advice on the use of existing treatment options and identifying outdated or ineffective treatments.

- Promote effective practices to professionals across the province.
- Conduct research into the effectiveness of care and quality improvement initiatives.
- Monitor and assess the performance of the health system. This will include providing advice on human resource needs.
- Provide advice on appropriate drug-prescribing practices.
- Evaluate new technology, drugs, and other clinical developments; and,
- Inform the public about the quality of health services in Saskatchewan.[5]

These innovative steps are being taken at the micro and mezzo level of the health care system. There is some encroaching onto the macro level in respect to "promoting effective practices to professionals" if one assumes that policy makers are professionals. Monitoring and assessing the performance of the health system can be rolled up to the macro level.

Alberta has established the Health Quality Council of Alberta as an arm's length organization empowered to report directly to Albertans on the quality, safety, and performance of health services. It has not to date developed as sophisticated a program of quality improvement as has occurred in Saskatchewan. Alberta has, however, demonstrated its commitment to improving health research by committing $500 million to the AHFMR. These initiatives are starting points for encouraging a discourse of how to more effectively bridge between the creation of new research evidence and the medical and health care challenges facing the provincial governments. The leadership provided by organizations like the CHSRF, CIHR, and CCOHTA on the national stage will provide some necessary impetus to move this agenda forward. The Ministers of Health from across Canada will need to collaborate and develop mechanisms by which they themselves can openly exchange and debate the pros and cons of various approaches that are tested in their jurisdictions as they attempt to facilitate closer and collaborative linkages among the epistemic communities. Undoubtedly the role of ideology and values will play prominently in their debates.

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[5] See Health Quality Council of Alberta Web site at http://www.hqca.ca/

The STEEPLE Model

In confronting the issue of how to deal explicitly with the values and ideologies surrounding health policy issues, it is recommended that the constituents of the STEEPLE model be adopted as a way of bringing the social sciences in to inform the discourse. The model, derived from T. Smith's (1991) analytical work and the PESTLE model developed in the U.K. Prime Minister's Strategy Unit (Government of the United Kingdom, 2005) is introduced below.

It is possible to provide policy makers with a pragmatic guide by mapping T. Smith's (1991) analytical model and my metaphorical model of the spinning top into a more practical checklist of specific social science, social ethics, and social policy disciplines that might be brought to bear on social or health care policy issues. Rather than creating a comprehensive list of social inquiry domains and methods, we will start with a simple model that captures the primary contemporary concepts that policy makers can grasp and utilize as a starting point. As health policy makers gain experience in working with researchers on these matters, the model can be expanded and refined. The mechanism proposed here is labelled the STEEPLE model (named after the first letter of each of its constituents):

S – Social and system demographics (empirical research, theories, models, selection of normative principles, evaluations)
T – Technology effects and effectiveness (evaluations, value analysis, strategies, tactics)
E – Environment (empirical research, theories, models, normative models, strategies, tactics)
E – Economics (empirical research, theories, models, value analysis, selection of normative principles, evaluations, normative models)
P – Politics (empirical research, theories, models, selection of normative principles, normative models, strategies, tactics)
L – Legislative/regulatory framework (empirical research, theories, models, selection of normative principles, evaluations, normative models)
E – Ethics (social ethics, values analysis, empirical research, theories, models, strategies, tactics)

Although evidence and information may never be the determining influence in policy decisions generally, there is value in exploring where evidence can make genuine contributions to policy debate. Researchers and analysts have much to offer the policy maker, often more than the policy maker recognizes. STEEPLE is a way to conceptualize doing policy analysis that helps the researcher and analyst provide a more complete set of evidence and information for the decision maker. The model contains a broad perspective and elements or areas of information that are not normally explored by policy analysts.

The seven major categories describe the kinds of questions or information that policy decision makers tend to use, formally or casually, admitted or not, as well as a couple of categories that perhaps should be used more frequently. The mnemonic STEEPLE does not imply an order within which an analysis would proceed, although that may be the case in some aspects. Nor does it imply the way the analysis should be reported. It does allow useful combinations and permutations of categories for the analysis where these would be useful. For example, technology and environment could be combined in an analysis, as could politics, legislation, and ethics. In other policy studies, all categories may best be kept separate. In other words, the mnemonic is simply a mnemonic; it should not be invested with any particular meaning. Regardless of how an analysis is approached, no category can be completely dealt with on its own. Analysis in one category can often influence the analysis in another.

Although these major categories with appropriate adjustments apply to all public policy, whether it is environmental, business, economic, social, cultural, or health, in this project I apply the model to health policy issues. In this application, the decisions required are usually along the line of whether to add a new technology or service, or whether a treatment, diagnostic, or other procedure should be added to the list of insured or publicly funded services. In the past few years, the nature of evidence that is used or should be used in policy decisions has been the subject of debate. The STEEPLE model, however, is based on the premise that multiple types of evidence and methods are necessary to produce a rounded understanding of the problem, the proposal, and the politics of the situation. Evidence is taken here as meaning a thing or things helpful in forming a conclusion or judgment. A hierarchy of evidence, which assigns different value to different types of evidence (clinical versus ethnographic), simply is not a useful conceptualization for the STEEPLE model as a whole, although such hierarchies may have value within some components of the model (e.g., being able to differentiate good studies of the values of a community from a poorly constructed study). In the following sections, some of the types of evidence that could be brought to bear will be mentioned.

In any given actual decision, not all parts of the STEEPLE model would be relevant. Part of the art of policy analysis is determining what information or evidence is central to making a decision, what evidence is peripheral, and what evidence is not needed. The STEEPLE model simply allows policy researchers, analysts, and decision makers to conceptualize the different categories of information that may be useful to a decision.

The STEEPLE model provides us with an opportunity to lay the foundation for what might be tested in the future as a "best practice" in health care policy making. To date, little work has been done on best practice in policy making in Canada. Several of the informants in this study did state that best practice in policy making is an oxymoron: It is impossible because of the contingent and situational aspects of the process. It cannot be reduced to technical requirements; rather, it is an art and craft. The difficulty with this point of view is that without some guidance, it leaves too much opportunity for undisciplined thinking and political expediency to be operationalized. Somewhere between the nihilistic relativism of "anything goes" and the extreme absolutism of "it must be done this way," there must be some middle ground for a best practice to be defined. The STEEPLE is one step forward in beginning to articulate a pragmatic approach to some of these requirements. The STEEPLE model is developed below through an example of a policy maker considering the introduction of a new health care intervention into the publicly funded health care system.

Social and system demographics

Social and system demographics is intended to present the decision maker with an understanding of who is affected by the identified problem or who is affected by the conditions that have been defined as a problem, the extent or distribution of the problem, and what society is presently doing about it. This last element includes the operation of whatever services and service systems have been established to deal with the problem. Using the application to health technology policy as an example, the social and system demographics element would primarily be an examination of the patterns of illness and the current patterns of care.

Patterns of illness, the description of who is affected along with the extent of the problem, deals with the population dynamics of affected patients. What are the trends in prevalence and incidence of the identified condition(s)? What is the age/gender structure of the affected population? What is the ethnic/cultural mix? What is the socioeconomic status (education and income)? The answers to some of these questions, (e.g., socioeconomic status) may simply show that identifiable subpopulations are not involved, that the problem crosses social and cultural boundaries. The involvement of identifiable subpopulations raises questions such as access to appropriate services, prerequisites of health, and the ethics involved in responding or not responding to the problem.

Another area of interest is the burden that the problem has on the individual affected, in this application, the burden of illness. This area of information includes a description of the condition or illness; the usual progress of the condition, or the natural history of the illness; the psychosocial effects of the condition on the individual; the economic effects such as the additional costs due to the condition, the ability to earn a living, and the income supports that may be necessary; and the effects of the condition on physical activity and lifestyle. This type of evidence can be generated from domains that have not been frequently called upon to inform health policy questions, sociology and anthropology, with approaches from the qualitative sciences such as biography, ethnography, GT, and phenomenology.

The system demographics for a health technology policy issue would be related to the patterns of care. It might include a brief history and development of treatments or other services used for the condition or illness. It would definitely include an analysis of the current treatment options and identify the present standard treatment or services, an overview and trends of use of different treatment options,[6] and the effect of patient or population characteristics on access to current treatment options, especially the standard treatment.

System demographics would also include the analysis of the capacity of the health system to provide care. What are the trends in the number and distribution of practitioners and support staff capable of providing service, both for the current standard treatment and the proposed treatment or services? What is an appropriate patient-practitioner ratio? What is the effect of these system constraints on access to service?

The evidence for social and system demographics ranges from population surveys to case studies to program evaluations. Experimental or controlled studies of any nature are rarely done in this area and when they are done, may be complementary but rarely answer the questions posed here; qualitative methods tend to yield rich insights.

Technology effects and effectiveness

In its broadest definition, the technology component would cover all the technology or techniques that are involved in the problem, either affecting the condition itself or used to deal with the condition. When applied to health technology policy, the technology component becomes technology effects and effectiveness and deals primarily with the new technologies or services being proposed to deal with the condition. Information that could be required in this area includes a basic understanding of what the technology has been approved for within Canada, evidence of what clinical condition(s) the technology has been approved for by regulatory agencies such as Health Canada, details of the etiology of the condition(s) the technology is meant to treat, identification of the clinical indicators for the use of the new technology, the acceptance of the technology in professional practice in Canada, and what the best practice for the condition(s) is currently thought to be.

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[6] This overlaps economic evaluation analysis (see below) only slightly. This topic looks at typical utilization patterns (where evidence exists) but not costs, whereas the economic evaluation looks specifically at the costs (based on utilization) of the technology in question and the specific comparator.

Another area of information that may be needed deals with the program context. Is there a need for a wider program of intervention for the proper use of the technology? What would this program look like? Is there a requirement for other technologies for appropriate use of target technology or ability to use equipment already in use for publicly funded procedures? What follow-up or related care would be required to maintain the outcomes? What would be the effect on related or follow-up treatments or care that would be required by current treatments?

Finally, the question of effectiveness needs to be examined. What is the available evidence of benefit or effectiveness? Are the outcomes achieved dependent on patient characteristics, specific training or experience of the providers (the learning curve), equipment used, or any other factors?

Assessing the effects and effectiveness of a technology or service requires different kinds of evidence depending on the technology or service being assessed. For medical technologies, a systematic review of a hierarchy of evidence giving RCTs a prominent place may well provide the best evidence. For behavioural interventions or similar services, program evaluations that do not include RCTs may still be useful.

Environment

Except in environmental policy itself, questions about environmental impacts are not usually asked. Nevertheless, given the recent prominence of environmental issues, all public policy should have an environmental (physical and manmade) assessment performed. This is particularly relevant at a time when population health as an emerging field is demonstrating a strong relationship between the determinants of health and the health of a population. The nature and extent of an environmental assessment would vary considerably depending on the policy issue concerned. For health technology policy, the primary environmental concerns would be whether, in comparison to standard treatments, the new technology would result in any increases in medical waste or other pollutants, there would be environmental safety issues for workers such as radiation risks, or, more generally, there would be significant energy consumption effects. In an actual health technology analysis, environmental effects can be dealt with as part of the technology effects and effectiveness. Again, systematic reviews of natural and physical science studies, complemented by case studies from sociology, would likely provide the best evidence.

Economics

Virtually all public policy has an economic component, usually involving the provision of funding within government budgets to cover the costs of service, the costs of providing a program, or the costs of regulating. However, sometimes it is the only component. Much public policy also affects the economy of the jurisdiction (e.g., taxation policy influences the growth or evolution of certain types of enterprises). Hence, the economic component of public policy analysis can cover a great deal of ground, even when the model is applied to health technology policy.

Economic evaluation of the technology may include an analysis of the distribution and concentration of rewards and costs or the economic incentives and disincentives for using the technology. If direct government funding is involved, will the adoption of the technology influence government's revenue stream, that is, what is the multiplier effect of adopting the new technology? What is the effect on employment of the new technology? Is this a net positive effect or net negative effect?

Introducing new technologies will have effects on the market for the old technologies and related technologies and services. What effects or shifts may occur? What external economies or diseconomies (individual as well as social) will adoption of the new technology generate? How do these affect the real costs of the technology?

A large part of the economic evaluation of new health technologies deals with the questions of cost and utilization. The analysis would need to include, for example, the unit and capital costs of the technology and associated services, the cost-effectiveness or cost-benefit of the technology, utilization trends, and cost trends and cost transfers from displaced services. Broadening the scope of the studies to social externalities of the costs to society and groups of individuals would be necessary as well. The evidence used here is primarily economic in nature, but may also involve quality-of-life measurements and other qualitative evidence of benefits in the cost-benefit analyses.

Politics

Two other things we need to capture in STEEPLE are the articulation of values/ideology, and citizen's opinions; these can often be captured with deliberative polling, citizen juries, and opinion polls. Commonly politics—the means and ways that people in groups interact in the achievement of their goals—is not consciously included in policy analysis or development. Policy analysts tend to work within a political environment and take that environment for granted. In fact, modern policy science has tended to go further and believes that politics has no place in policy science. As Fischer (1987) puts it:

> ... the policy science movement and its literature naively cling to a number of outdated assumptions. One is the overly simplistic assumption that better policy knowledge will lead to improved policy decisions. Another is the idea that good policy science is "value neutral." There is little in the contemporary experience that demonstrates the reliability of either assumption, although both remained firmly grounded in the discipline. Taken together, they perpetuate one of the discipline's most powerful myths: mainly, that the concerns of policy science, if not all policy experts, transcend the play of politics. (Fischer, 1987, p. 95)

It is the premise of the STEEPLE approach that politics, conscious or not, is very much a part of policy analysis and development.

Although it may not always be a conscious element in a policy decision, the governance domain is usually quite aware of the political support or resistance to any given decision. However, the more controversial a policy may be, the more conscious everyone is of the politics involved. In almost every case, though, stepping back from that taken-for-granted environment and exploring how that environment affects a policy decision can be valuable.

A good starting point for any analysis of the politics of a situation is current government policy. What does the government see as its role or what is its political philosophy? What is the ideology surrounding the issue? Does the government see itself as activist or interventionist? Does it see itself as primarily concerned with maintaining the existing structures and values of society? This preconception of its role usually persists over time, changing only when new parties are elected to govern. Nevertheless, it is useful for policy analysts and developers to reflect on this role from time to time. Ways of doing this include an analysis of the recent government decisions, especially on similar policy issues, as well as government business plans or published goals.

Aspects of government policy that can and do change in shorter time frames include the social and/or economic goals and priorities for the jurisdiction. These would be pertinent in any application of the STEEPLE model. In the case of health technology policy, similar questions need to be asked about health system goals and priorities, health funding policy (the balance between full public funding, partial public funding, or wholly private funding), and cross-jurisdictional alignment and issues.

A more overt political analysis would deal with the degree to which any given condition has been defined as a problem by the decision makers, as well the degree to which they see the proposed technology, as opposed to alternatives, as a solution. It would also consider other processes or events that are influencing the decision.

Some understanding of the stakeholders and others affected by the decision is also needed. In the case of health technology, what would be the effect of the decision on manufacturers and suppliers of the new technology, as well as of the current technologies? What would be the effect on providers and support staff? Will benefits accrue differently to those who adopt the new technology early than to those who adopt it late or not at all? How are patients, their families, and other caregivers affected? Are there any specific groups or identified subpopulations affected? How? What is the effect, if any, on the general public? In performing a stakeholder analysis, it is often useful to consider the four Rs: **R**ights, **R**esponsibilities, and expected **R**ewards or gains for each of the stakeholder groups and the **R**elationships between the groups.

The information specified in this section has not often been considered legitimate research evidence, even in the broadest sense of the term. Much of it has been surmise and guesswork; some is anecdotal and some is simply documentary. Drawing from the disciplines of political science and public policy, the quality of evidence brought to bear on the issues can be improved and increased substantially

Legislation/regulatory framework

Not all policy issues involve legislation, which is usually taken to include any regulations made pursuant to the statute involved. Many government programs or other initiatives are simply covered by enabling legislation. In these cases, the value in investigating the legislative framework is small. In some areas, though, the legislation and regulations affecting the policy decision are both enabling and restricting. It is in these latter cases that a thorough understanding of the effect of the legislation on the options being considered is required.

In addition to the legislation of the jurisdiction considering the policy decision, sometimes an understanding of the applicability of legislation or agreements in a superior, parallel, or subordinate jurisdiction is needed. Recently, many policy initiatives have needed to consider the potential effects of the North American Free Trade Agreement and the Kyoto Accord, and in the case of health technology policy, federal legislation such as the Canada Health Act and the Food and Drugs Act. In some cases, there may also be pending legislation or regulation that may apply to the issue, making it more difficult to deal with because of the confidentiality that often surrounds new legislation until it is introduced in the legislature.

Again, the information contemplated by this area of analysis has not been susceptible to scientific rigour, although there are specific principles of interpretation applicable to legislation and regulation that need to be considered. The fields of health law, political science, and public policy would be instrumental in providing evidence to help inform questions arising.

Ethics

Ethical analysis of a policy decision is something that is not commonly undertaken. The Prime Minister's Office in the United Kingdom, which encouraged the development and use of the PESTLE model, does not include a separate category for ethical analysis (Government of United Kingdom, 2005). Pragmatists believe that ethics has no part in policy decisions, arguing that policy is a balance of competing interests and interest groups with no right or wrong choices and that ethical consideration simply interferes with the bargaining process. The STEEPLE model is predicated on the contrary position that the identification of the ends sought in a policy decision, examination of the values embodied in those ends, and assessment of the extent to which the ends are in keeping with the values of society are an important part of a complete policy analysis. This analysis also needs to be broadened to examine each of the proposed alternatives for the ends and the values embedded in them.

When attempting to assess the ends against societal values, consideration needs to be given to the extent that values are shared across stakeholders. Where do they conflict, where are they neutral, and where does a consensus exist? In addition to assessing options against the identified values of stakeholders, an ethical analysis also assesses options against typical ethical models: the common good, fairness and equity, benefit-harm ratios, and individual choice. None of these ethical models holds a complete answer, but it is useful to understand the options from the different perspectives.

Once again, research evidence in its traditional form has not been brought directly to bear on these issues, but the evidence offered of social impacts and technological effectiveness, for example, are certainly useful as a foundation for the ethical analysis. The fields of ethics, philosophy, political philosophy, political sociology, and political science can be constructive in exploring many of the questions.

The development, embedding, and sustenance of mechanisms whereby scientific evidence, ideology, values, and opinions are explicated through the standardized and consistent application of the STEEPLE model would move some distance in providing guidance on the accommodation of health care policy that is publicly accountable. The following algorithm describes the fundamental accommodation that would take place among the various forms of HQE to inform policy making.

$$\text{Accommodation of Health Care Policy} = \text{Scientific Evidence} + \text{Ideology} + \text{Values} + \text{Opinions}$$

I propose a set of best practices in Tables 39 and 40 in Appendix F for accommodation along the dimensions of structure, process, output, and outcome. These are not definitive but a starting point for discussion about introducing best practice into a health department or health care delivery system

Traction

Traction, or how well Canada is doing in the implementation of strategies and mechanisms for improving the health status of its citizens through health care policy making, is a daunting task. The fact that health care is a provincial jurisdiction may be an opportunity to pilot different forms of public policy approaches supported with HQE in the different provinces to assess what may be the most effective approaches. The National Health Council could be given the role to develop, implement, monitor, and report to Canadians on this progress.

The limitations and weakness on achieving traction at the national level is that agreement on details among the provinces is difficult to achieve. Invariably, Alberta positions itself on the side of "innovation" in health care and Saskatchewan positions itself on the "fundamental principles" of the Canada Health Act. One way forward might be to delegate the responsibility to the provincial health quality councils to monitor and report on the health status of the population but in accordance with nationally agreed upon population health indicators that could be arrived at by the CIHI.

The epistemic communities and improving health policy making

My thesis utilizes and extends the concept of epistemic communities to provide a framework for advancing our conceptualization of the transaction of ideas between and among politicians, policy makers, researchers, and elite citizens. The model is an effective way of identifying the shared norms and values of the groups, what they consider as "legitimate" knowledge, their causal beliefs, possible policy actions in the future, and their preferred outcomes. These characterizations are drawn into the tables developed in the summaries in section 3. Taking the characterizations of the tables and collapsing them further by each of the epistemic communities, Table 32 is derived. Future actions derived from these characterizations are described below.

Table 32: Epistemic Communities and Dimensions for Establishing Improved Health Policy Making

DIMENSIONS	POLITICIANS	POLICY MAKERS	RESEARCHERS	CITIZEN ELITES
Practice	Support democratic principles balancing role of state and individual	Introduce commitment to best practice in policy making	Refine methods of positivist and postpositivist approaches	Educate enlightened citizens in active civic duty
Linkages	Demonstrate commitment to consultation and communication	Facilitate an inclusive and unconstrained culture of inclusion	Retain autonomy but integrate into lifeworlds of other epistemic communities	Meaningful citizen participation
Accommodation	Provide leadership and commitment to address issues of the marginalized	Bridge knowledge creation and its application for emancipatory health policy	Create new knowledge to improve effectiveness of accommodation	Mechanisms for bringing health needs to the policy table
Traction	Hold legislature accountable for the population health	Document and publish outcomes of policy interventions	Create new knowledge to monitor and report population health	Monitor population health

Opportunities and challenges for epistemic communities

High-level actions arising for the politicians include the continued development of the democratic state balanced with individual liberty. There is strong encouragement for more meaningful linkages and exchanges between the citizen community and the policy-making processes. Politicians should be prepared to deal with the contested terrain that will emerge from the conciliation of positivist recommendations and those emerging from the postpositivist tradition. Discourse encouraging a redistribution of wealth to respond to the socioeconomic needs of the marginalized in society is one form of this discourse. Recommendations for focusing more on prevention and health promotion may be perceived to come at the expense of the curative medical system that appears to have plateaued in making any further improvements in population health through the infusion of additional resources. The traditional medical and nursing establishments may campaign against reforming the health system in a way that threatens their practice. Having taken on these challenges, politicians will be required to hold themselves to a high standard of accountability for the resulting improvements. Realistically, this kind of change cannot occur rapidly, but some form of long-term goals for the next 25 to 50 years should be established to move Alberta and Saskatchewan society in that direction. It appears as if Saskatchewan may well have a head start. In both cases, the legislature will be the final arbiter of the performance of government.

Policy makers are placed in the very awkward and challenging position of having to establish a code of best practice that is no longer focused on brokering influence and vested interest behind closed doors but rather on mediating ideas about how an educated public is able to achieve their best health. What is currently identified as a very difficult task in public policy making using primarily traditional scientific evidence is certain to be made more difficult as new forms of knowledge from the social sciences are brought forward to inform the discussion at the policy table. Further challenges involve facilitating a more open, explicit, and transparent process, with the public in undertaking policy development, but doing it in a constrained and professional manner in which the boundaries of actors are maintained. The process of accommodation will require new skills and competencies as new forms of knowledge are brought in to complement traditional scientific knowledge on how to advance the population health agenda in the province. It is essential that the academic and policy-making communities come to some agreement as how to establish graduate training for health policy makers that is prepared to deal with the challenges of the next 50 years. The means of the past will not sustain a policy-making process that brokers power and influence rather than ideas with merit. The policy-making community will also be responsible for facilitating the reporting of population health outcomes from the policy interventions.

HSR and allied researchers have an opportunity to make a significant and meaningful contribution to improving the health-policy-making process in society and potentially the health of the population. Retaining academic autonomy but at the same time being relevant and timely, with key research projects responding to the challenges of the provincial health research agenda will be a difficult challenge. The task is made difficult because of the lack of appropriate incentive structures and a lack of patience on the part of the political, policy-making, and citizen establishments to catch up to what the discursive community identifies as such obvious "winners" in terms of health policy action (e.g., the banning of smoking in public places). Researchers will also be called upon to provide solid evidence to reconcile the competing and constraining contradictions arising from the dissonance between practice and emerging discursive knowledge. There are many opportunities for researchers to make an impact at all stages of the policy-making process.

Citizen elites, with their responsibility to protect the public interest, are also well positioned to make a significant contribution to population health. The citizen elites interviewed in the course of this study were "converts" to how the health care system ought to be reformed to improve population health, so there is no difficulty in finding ways in which the discursive knowledge is confluent with their idea of best practice. What appeared to be at issue was whether the political will was present to move the agenda forward. Greater emphasis on the education of the public appears to be necessary so that politicians do not feel as if they are working against the "public interest" when, for instance, they rally in favour of banning smoking in public places. The strategy for this challenge will involve some review and changes to the kindergarten to grade 12 school curriculum and community development models, including adult lifelong learning, to identify ways in which a more realistic perception of citizen health and risk behavior about healthy living and disease will result. The programs that prepare our health care providers will also need to be examined to identify ways in which prevention and health promotion are encouraged. Teaching health care professionals to work as a team and within a system will also be important messages. A well-educated and enlightened citizenry will more easily reach its emancipation than one that is deprived. Thus, central to my study of the public sphere of health reform is the presupposition of a need for understanding and promoting public education beyond restricted notions of public schooling.

Future opportunities

The model developed in my thesis must be tested in order to determine if improved health policy making does result from the explicit, transparent, and open integration of evidence, values, ideology, and opinions into the policy-making process. The view of informants is that as long as evidence is used without having been attenuated by the values, ideology, and opinions surrounding an issue, that evidence will only be as strong as the weakest link, which begins to criticize and mobilize other interests to displace the findings of the evidence. The banning of smoking in all public buildings is an example of where the best HQE continues to be stymied by ideology, values, and opinion that either smoking is not detrimental to one's health or that the state intervention to limit it is an inappropriate encroachment on individual liberties – with or without consideration for the consequences for those inhaling secondhand smoke. Creating new knowledge about healthy living and having it change behaviour so that people do things for the right reasons is an ideal, but in the meantime, negative encroachments onto individuals' liberties may be justified by the state where the improved benefits in population health exceed the negative consequences of limiting the liberty of individuals. The mandatory introduction of wearing seat belts in automobiles is an example of what was a threatening concern to individuals' liberty that is now being accepted by the vast majority of the population as appropriate and necessary. Diminishing ignorance or inappropriate risk-taking behaviour without intruding on people's liberties is a difficult challenge. Undertaking further research to better understand the values and motivators behind smoking and what forms of public policy resulting in incentives would discourage smoking are important new knowledge to be pursued. New knowledge may be gleaned from the qualitative methods that are underutilized in HSR. In order for social progress to be achieved with HQE, it must have the opportunity of responding to the values, ideology, or opinions in an open and transparent way so that the public's debate around them and the public's knowledge can be advanced.

One of the ways of improving the contribution that the discussion of values, ideology, and opinions can make during the policy cycle is to increase the capacity for conducting qualitative and mixed methods research to provide visibility and relevance to the issues and local context that the policy makers and politicians argue are absent. In a practical sense, increasing capacity means making more financial support available for these forms of research but also improving the capability of the research community to conduct HSR. Central to this capacity building is the need for greater collaboration among the epistemic communities in the form of alliances, partnerships, and linkages.

Recommendations for future research

My project has identified one way forward in addressing the challenge of bringing health care policy makers and the research community closer together to inform questions and issues in health care policy. As was identified in the weaknesses and limitations sections in the previous chapter, there are a great number of questions for which there are no clear answers. Below are a series of recommendations for future research that might be considered appropriate for the health policy research agenda. The focus on the research questions here is on issues that would be confronted among the four epistemic communities in this study.

- Is the model developed in this thesis effective in improving health care policy making at the provincial level? Conduct a pilot project.
- What are effective mechanisms to identify and prioritize the health policy research agenda in the provincial context and on the national landscape?
- What mechanisms are available for reviewing and assessing the quality of primary and secondary HSR, whether it arises from the quantitative, qualitative, or mixed methods?
- How can a policy maker effectively manage and mitigate the risk surrounding a policy issue in which there is a level of uncertainty and a short time frame for resolution of the issue?
- What are effective ways of problematizing an issue statement surrounding different types of health care policy issues?

- Can the impact or influence of HSR on the policy-making process be determined and assessed?
- Can the impact or influence of HSR on the health of the population be determined and assessed?
- What are the core competencies of a policy maker in a department of health?
- What forms of uncertainty are there in the utilization of knowledge in policy making and how does one undertake a policy response to them?
- What forms of bias arise in conducting social sciences research to inform a health policy issue?
- How does one effectively integrate research evidence from social science and social ethics to inform social policy?
- What are best practices in health care policy making at the macro, mezzo, and micro levels of a health care system?
- What are the approaches to evaluating the effectiveness of health care policy processes?
- What are the strategies and mechanisms that policy makers can use to respond to influences of political expediency?
- What are the processes by which embodied, practical, and discursive knowledge move between politicians and policy makers?
- What characteristics and qualities of policy making improve the likelihood of it having traction?
- How can policy makers look ahead to anticipate the health care issues that are likely to impinge on their work?
- What are effective ways of educating the public on the contemporary health care issues?
- What are effective mechanisms for dominant professionals in the health care system to participate in health care policy making without unduly influencing it to their benefit?
- What are effective ways of including the public and stakeholders in health care policy making?

This is not meant to be an exhaustive list. It is an attempt to identify the kinds of research questions that arose during the course of completing this study. The range of questions suggests that there is a great deal of work to do and that disciplines in the social sciences have a significant contribution to make. In closing, I am encouraging politicians, policy makers, researchers, and citizens to work together to build a community of HSR excellence where creating and applying high-quality evidence by taking into account opinions, values, and ideology to debate the question of "What health policy reforms will best improve the health of the citizens of Alberta and Saskatchewan?" is a top priority.

REFERENCES

1. Abbott, A. (1988). *The system of professions*. Chicago: University of Chicago Press.

2. Abelson, D. E. (2002). *Do think tanks matter?: Assessing the impact of public policy institutes*. Kingston, Canada: McGill-Queen's University Press.

3. Abelson, J., Forest, P. G., Eyles, J., Smith, P., Martin, E., & Gauvin, F. P. (2003). Deliberations about deliberative methods: Issues in the design and evaluation of public participation processes. *Social science and medicine, 57,* 239-251.

4. Alberta Heritage Foundation for Medical Research (2003). Health research agenda for Alberta. Retrieved January 23, 2004, from http://www.ahfmr.ab.ca/programs.html

5. Alford, R. (1975). *Health care politics: Ideological and interest group barriers to reform*. Chicago: University of Chicago.

6. Anderson, O. (1972). *Health care: Can there be equity?* New York: Wiley.

7. Angus, D. E. (1991). *Review of significant health care commissions and task forces in Canada since 1983-84*. Ottawa: Canadian Medical Association, Canadian Nurses Association, Canadian Hospital Association.

8. Angus, D. E., Auer, L., Cloutier, J. E., & Albert, T. (1995). *Sustainable health care for Canada*. Ottawa: Queen's-University of Ottawa.

9. Archer, M. S. (2000). *Being human: The problem of agency*. Cambridge, England: Cambridge University Press.

10. Barlow, M. (2002). *Profit is not the cure: A citizen's guide to saving medicare*. Toronto: McClelland & Stewart.

11. Bendix, R. (1956). *Work and authority in industry*. New York: Wiley.

12. Benhabib, S. (2002). Toward a deliberative model of democratic legitimacy. In S.Benhabib (Ed.), *Democracy and difference: Contesting the boundaries of the political* (pp. 67-94). Princeton, NJ: Princeton University Press.

13. Bhatta, G. (2002). Evidence-based analysis and the work of policy. *Research and Evaluation, 61,* 98-105.

14. Black, N. (2001). Evidence based policy: Proceed with care. *British Medical Journal, 323,* 275-279.

15. Blackburn, S. (1996): *The Oxford Dictionary of Philosophy*. Oxford, England: Oxford University Press.

16. Bogenschneider, K., Oleson, J. R., Linney, K. D., & Mills, J. (2000). Connecting research and policymaking: Implications for theory and practice from the family impact seminars. *Family relations, 49,* 327-339.

17. Bowling, A. (1997). *Research methods in health: Investigating health and health services*. Buckingham, England: Open University Press.

18. Boychuk, G. W. (2002). Federal spending in health: Why here? Why now? In G.B.Doern (Ed.), *How Ottawa spends 2002 - 2003: The security aftermath and national priorities* (pp. 121-136). Don Mills: Oxford University Press.

19. Browne, J. (1975). *Summary of recent major studies of health care in Canada*. Ottawa: Canadian College of Health Service Executives.

20. Bryant, T. (2002). Role of knowledge in public health and health promotion policy change. *Health promotion international, 17,* 89-98.

21. Canadian College of Health Service Executives. (1994). *External environmental analysis and health reform update: Special report*. Ottawa: Author.

22. Canadian College of Health Services Executives. (2004). *Health systems update 2003-04*. Ottawa: Author.

23. Canadian Health Services Research Foundation (2003). Communication notes: Reader-friendly writing. 1:3:25. Retrieved December 1, 2003, from http://www.chsrf.ca/docs/resource/cn-1325_e.pdf

24. Canadian Health Services Research Foundation. (1999). *Issues in linkage and exchange between researchers and decision makers.* Ottawa: Author.

25. Canadian Health Services Research Foundation. (2000). *Health services research and ... Evidence based decision-making.* Ottawa: Author.

26. Canadian Health Services Research Foundation. (2005). Making research work. Retrieved June 12, 2005, from http://www.chsrf.ca/home_e.php

27. Canadian Institute for Health Information. (2003). Statistical report on the health of Canadians. Retrieved June 13, 2004, from http://www.hc-sc.gc.ca/hppb/phdd/pdf/report/stats/eng78-84.pdf

28. Canadian Population Health Initiative & Canadian Institute for Health Information (2002). *Tools for knowledge exchange: Scanning best practices in policy research.* Ottawa: Canadian Institute for Health Information.

29. Carmichael, D. J. C. (1985). Political ideologies and values. In T.C.Pocklington (Ed.), *Liberal democracy in Canada and the United States* (pp. 58-90). Toronto: Holt, Rinehart and Winston of Canada.

30. Carroll, W. K. & Shaw, M. (2001). Consolidating a neoliberal policy bloc in Canada, 1976 - 1996. *Canadian Public Policy, 27,* 195-217.

31. Church, J. & Barker, P. (1998). Regionalization of health services in Canada: A critical perspective. *International Journal of Health Services, 28,* 467-486.

32. Clemons, R. S. & McBeth, M. K. (2001). *Public policy praxis.* Upper Saddle River, NJ: Prentice-Hall.

33. Cohen, C. (1999a). Deliberation and democratic legitimacy. In J.Bohman & W. Rehg (Eds.), *Deliberative democarcy: Essays on reason and politics* (pp. 67-91). Cambridge, England: MIT Press.

34. Cohen, J. (1999b). Procedure and substance in deliberative democracy. In J.Bohman & W. Rehg (Eds.), *Deliberative democracy: Essays on reason and politics* (pp. 407-437). Cambridge, MA: Massachusetts Institute of Technology.

35. Commission on Medicare. (2001). *Caring for medicare: Sustaining a quality system.* Regina: Government of Saskatchewan.

36. Commission on the future of health care in Canada (2002). *Building on values: The future of health care in Canada* Ottawa: Commission on the Future of Health Care in Canada.

37. Cooper, B. & Kanji, M. (2000). *Governing in post-deficit times: Alberta in the Klein years.* Toronto: University of Toronto.

38. Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

39. Crichton, A., Hsu, D., & Tsang, S. (1994). *Canada's health care system: Its funding and organization.* Ottawa: CHA Press.

40. Crichton, A. (1981). *Health policy making: Fundamental issues in the United States, Canada, Great Britain and Australia.* Ann Arbor, MI: Health Administration Press.

41. Cunningham, F. (2002). *Theories of democracy: A critical introduction.* New York: Routledge.

42. Danermark, B., Ekstrom, M., Jakobsen, L., & Karlsson, J. (2002). *Explaining society: Critical realism in the social sciences.* London: Routledge.

43. Davidson, A. R. (1999). *Health care reform in British Columbia dynamics without change.* The University of British Columbia, Vancouver.

44. Davies, P. S. (2004). Is evidence-based government possible? In *Jerry Lee Lecture 2004* Washington, DC.

45. Davis, S. M. (1992). *Health care innovation, impact and challenge.* Kingston: School of Policy Studies Queen's University.

46. Deber, R., Baker, R., & Mhatre, S. (1992). Review of provincial systems. In S.M.Davis (Ed.), *Health care: Innovation, impact and challenge* (pp. 9-24). Kingston: School of Policy Studies/School of Public Administration.

47. Denzin, N. K. & Lincoln, Y. S. (2000). *Handbook of qualitative research.* (2nd. ed.) Thousand Oaks, CA: Sage.

48. Dobbins, M., DeCorby, K., & Twiddy, T. (2004). A knowledge transfer strategy for public health decision makers. *World Views on Evidence-Based Nursing, 1,* 120-128.

49. Dorland, J. & Davis, S. M. (1996). *How many roads...? Regionalization and Decentralization in Health Care.* Kingston: Queen's University: School of Policy Studies.

50. Drache, D. & Terry, S. (1999). *Market limits in health reform: Public success, private failure.* London: Routledge.

51. Dye, T. R. (1984). *Understanding public policy.* Englewood Cliffs, NJ: Prentice-Hall.

52. Easton, D. (1965). *A framework for political analysis.* Englewood Cliffs, NJ: Prentice-Hall.

53. Eckstein, H. (1960). *Pressure group politics: The case of the British Medical Association.* London: Allen & Unwin.

54. Ehrenreich, J. & Ehrenreich, B. (1971). *The American health empire.* New York: Random House.

55. Etzkowitz, H., Webster, A., & Healey, P. (1998). *Capitalizing knowledge: New intersections of industry and academia.* Albany, NY: State University of New York Press.

56. Fischer, F. (1987). Policy expertise and the 'new class': A critique of the neoconservative thesis. In F.Fischer & J. Forester (Eds.), *Confronting values in policy analysis: The politics of criteria* (pp. 89-99). Newbury Park, CA: Sage.

57. Friedson, E. (1970). *Professional dominance: The social structure of medical care*. New York: Atherton.

58. Fuller, S. (2002a). *Knowledge Management Foundations*. Woburn, MA: Butterworth-Heinemann.

59. Fuller, S. (2002b). *Social Epistemology*. (2 ed.) Bloomington, IN: Indiana University Press.

60. Fuller, S. (2000). *The governance of science*. Philadelphia, PA: Open University Press.

61. Fulop, N., Allen, P., Clarke, A., & Black, N. (2003). From technology assessment to research on the organization and delivery of health services: Addressing the balance. *Health Policy, 63,* 155-165.

62. George, A. L. (1979). Case studies and theory development: The method of structured, focussed comparison. In P.G.Lauren (Ed.), *Diplomacy: New approaches in history, theory and policy* (pp. 43-68). New York: Free Press.

63. Giacomini, M., Hurley, J., Gold, I., Smith, P., & Abelson, J. (2001). *'Values' in Canadian health policy analysis: What are we talking about?* Ottawa: Canadian Health Services Research Foundation.

64. Gibbins, R. & Youngman, L. (1996). *Mindscapes: Political Ideologies Towards the 21st Century*. Toronto: McGraw-Hill Ryerson Ltd.

65. Glazer, W. (1970). *Social settings and medical organization*. New York: Atherton.

66. Government of Saskatchewan (1990). *Future directions for health care in Saskatchewan* Regina: Public Affairs Branch.

67. Government of the United Kingdom (2005). Prime Minister's strategy unit. Retrieved May 9, 2005, http://www.strategy.gov.uk/

68. Haas, P. M. (1992). Introduction: Epistemic communities and international policy coordination. *International Organization, 46,* 1-35.

69. Hall, J. R. (1999). *Cultures of inquiry: From epistemology to discourse in sociohistorical research.* Cambridge, England: Cambridge University Press.

70. Hall, P. A. (1993). Policy paradigms, social learning and the state. *Comparative Politics, 25,* 275-96.

71. Ham, C., Hunter, D. J., & Robinson, R. (1995). Evidence based policymaking. *British Medical Journal, 310,* 71-72.

72. Hamel, J. (1993). *Case study methods: Quantitative Research Methods Series.* (vols. 32) Newbury Park: Sage Publications Inc.

73. Hanney, S., Gonzalez-Block, M. A., Buxton, M. J., & Kogan, M. (2003). The utilisation of health research in policy making: Concepts, examples and methods of assessment. *Health Research Policy Systems, 1.*

74. Health Canada (1995). *Provincial health system reform in Canada.* Ottawa: Health Canada.

75. Health Canada (1996). *Provincial health system reform in Canada Update 1996.* Ottawa: Health Canada.

76. Howlett, M. (2002). Policy development. In C.Dunn (Ed.), *The handbook of Canadian Public Administration* (pp. 173-191). Don Mills: Oxford University Press.

77. Howlett, M. & Ramesh, M. (2003). *Studying public policy - Policy cycles and policy subsystems.* (2nd ed.) Toronto: Oxford University Press.

78. Innvaer, S., Vist, G., Trommald, M., & Oxman, A. (2002). Health policy-maker's perceptions of their use of evidence: A systematic review. *Journal of Health Services Research and Policy, 7,* 239-244.

79. Jary, D. & Jary, J. (2000). *Sociology Collins dictionary.* (3ed ed.) Glasgow, Scotland: Harper Collins.

80. Jerome-Forget, M., White, J., & Wiener, J. (1995). *Health care reform through internal markets experience and proposals.* Montreal: Institute for Research on Public Policy and Brookings Institution.

81. Jerome-Forget, M. & Forget, C. E. (1998). *Who is the master? A blue print for Canadian health care reform*. Montreal: Institute for Research and Public Policy.

82. Jreisat, J. (1999). Comparative public administration and reform. *International Journal of Public Administration, 22,* 855-877.

83. Kachur, J. L. (2002). The postmodern prince: Gramsci and anonymous intellectual practice. In C.Borg, J. Buttigieg, & P. Mayo (Eds.), *Gramsci and education* (pp. 307-330). Lanham, MD: Rowman & Littlefield.

84. Kachur, J. L. (2004). Intellectual property rights and the disciplining of higher education in Canada and Mexico. In M.Moll & L. R. Shade (Eds.), *Seeking convergence in policy and practice: Communication in the public interest* (pp. 159-182). Ottawa: Canadian Centre for Policy Alternatives.

85. Kachur, J. L. (2003). Whose intellectual property? Whose rights? GATS, TRIPS and Education in Canada. In R.Dale & Dr. S. Robertson (Eds.), *Special issue: WTO/GATS and the global education services industry* (pp. 375-411). Oxfordshire, England: Carfax.

86. Kachur, J. L. (1995). *Hegemony and anonymous intellectual practice.* University of Alberta, Edmonton.

87. Kachur, J. L. (1999). Orchestrating delusions: Ideology and consent in Alberta. In J.L.Kachur & T. W. Harrison (Eds.), *Contested classrooms: Education, globalization, and democracy in Alberta* (pp. 59-74). Edmonton: The University of Alberta Press: Parkland Institute.

88. Klein, R. (1995). *The new politics of the NHS*. London: Longman.

89. Landry, D., Amara, N., & Lamari, M. (2001). Utilization of social science research knowledge in Canada. *Research Policy, 30,* 333-349.

90. Landry, D., Lamari, M., & Amara, N. (2003). The extent and determinants of the utilization of university research in government agencies. *Public Administration Review, 63,* 192-204.

91. Lavis, J. N., Farrant, M. S. R., & Stoddart, G. L. (2001). Barriers to employment-related healthy public policy in Canada. *Health promotion international, 16,* 9-19.

92. Lavis, J. N., Ross, S. E., Hurley, J. E., Hohenadel, J. M., Stoddart, G. L., Woodward, C. A. et al. (2002). Examining the role of health services research in public policymaking. *The Milbank Quarterly, 80,* 125-154.

93. Lehoux, P., Tailliez, S., Denis, J. L., & Hivon, M. (2004). Redefining health technology assessment in Canada: Diversification of products and contextualization of findings. *International Journal of Technology Assessment in Health Care, 20,* 325-336.

94. Lemieux-Charles, L. & Champagne, F. (2004). *Using knowledge and evidence in health care.* Toronto: University of Toronto Press.

95. Lerner, D. & Lasswell, H. (1951). The policy sciences. In H.Laswell (Ed.), *The policy orientation* (pp. 1-15). Stanford, CA: Stanford University Press.

96. Lewis, S., Saulneir, M., & Renaud, M. (2000). Reconfiguring health policy: Simple truths, complex solutions. In *Social studies in health & medicine* (pp. 509-523). Thousand Oaks, CA: Sage.

97. Lifton, R. J. (1986). *The Nazi doctors: Medical killings and the psychology of genocide.* Cambridge, MA: Perseus Publishing.

98. Lincoln, Y. S. & Guba, E. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

99. Lomas, J. (1990). Finding audiences, changing beliefs: The structure of research use in Canadian health policy. *Journal of health politics, policy and law, 15,* 525-542.

100. Lomas, J. (2004). *Postscript: Understanding evidence-based decision-making - or, why keyboards are irrational.* Toronto: University of Toronto.

101. Lomas, J. (1997). *Improving research dissemination and uptake in the health sector: Beyond the sound of one hand clapping.* Hamilton: Centre for Health Economics and Policy Analysis.

102. McArthur, W., Ramsay, C., & Walker, M. (1996). *Healthy incentives: Canadian health reform in an international context.* Vancouver: The Fraser Institute.

103. Meilicke, C. & Storch, J. (1980). *Perspectives on Canadian health and social services policy: History and emerging trends.* Ann Arbor, MI: Health Administration Press.

104. Merriam Webster (2005). Merriam Webster Dictionary Online. Retrieved March 22, 2005, from http://www.m-w.com/cgi-bin/dictionary?book=Dictionary&va=traction

105. Miller, H. T. & Fox, C. J. (2001). The epistemic community. *Administration and Society, 32,* 668-685.

106. Moore, B. (1966). *Social origins of dictatorship and democracy.* Boston: Beacon Press.

107. Muir Gray, J. A. (2001). *Evidence-based healthcare: How to make health policy and management decisions.* Toronto: Churchill Livingstone.

108. National Forum on Health. (1997). *Canada health action: Building on the legacy: Final report of the national forum on health.* Ottawa: Minister of Public Works and Government Services.

109. Office of Science and Technology (2000). Guidelines 2000: Scientific advice and policy making. Retrieved March 17, 2005, from http://www.ost.gov.uk/policy/advice/guidelines_2000/

110. Osborne, T. (1998). Of health and statecraft. In A.Petersen & R. Bunton (Eds.), *Foucault, health and medicine* (pp. 173-188). New York: Routledge.

111. Pal, L. A. (1997). *Beyond policy analysis: Public issue management in turbulent times.* Scarborough: International Thomson Publishing.

112. Pal, L. A. (2001). *Beyond policy analysis: Public issue management in turbulent times.* (2nd ed.) Scarborough: Nelson.

113. Peters, S. (1995). *Exploring Canadian values: A synthesis report*. Ottawa: Canadian Public Research Networks.

114. Peterson, R. T. (1996). *Democratic philosophy and the politics of knowledge*. University Park, PA: Pennsylvania State University Press.

115. Pineault, R. (1992). The reform of the Quebec health-care system: Potential for innovation? In M.S.Davis (Ed.), *Health care: Innovation, impact and challenge* (Kingston: Queen's University Press.

116. Powell, F. & Wessen, A. F. (1999). *Health care systems in transition: An international perspective*. Thousand Oaks, CA: Sage.

117. Premier's Advisory Council on Health for Albertans. (2001). *A framework for reform.* Edmonton: Author.

118. Premier's Commission on Future Health Care for Albertans. (1989). *The Rainbow Report: Our vision for health (Vol. I)* Edmonton: Author.

119. Presthus, R. (1973). *Elite accommodation in Canadian politics*. London: Syndics of the Cambridge University Press.

120. Pross, A. P. (1986). *Group politics and public policy*. Toronto: Oxford University Press.

121. Ragin, C. (1989). *The comparative method: Moving beyond qualitative and quantitative strategies*. Berkeley, CA: University of California Press.

122. Redden, C. J. (2002). Health care as citizenship development: Examining social rights and entitlement. *Canadian Journal of Political Science, 35,* 103-125.

123. Rice, J. J. & Prince, M. J. (2000). *Changing politics of Canadian social policy*. Toronto: University of Toronto Press.

124. Rimlinger, G. (1971). *Welfare policy and industrialization of Europe, America and Russia*. New York: Wiley.

125. Rosen, G. (1953). Cameralism and the concept of medical police. *Bulletin of Historical Medicine, 27,* 21-42.

126. Royal Commission on Health Services (1964). *Report of the Royal Commission on Health Services.* Ottawa: Queen's Printer.

127. Rundall, T. (1999). Overview of the special supplement issue. *Health Services Research, 34,* 1091.

128. Sabatier, P. A. (1986). What can we learn from implementation research? In F.X.Kaufmann, G. Majone, V. Ostrom, & W. Wirth (Eds.), *Guidance, control, and evaluation in the public sector* (pp. 313-325). Berlin, Germany: Walter de Gruyter.

129. Sadker, D. (2005). Some practical ideas for confronting curricular bias. Retrieved June 4, 2005, from www.american.edu/sadker/curricularbias.htm

130. Saltman, R. B. & Figueras, J. (1997). *European health care reforms: Analysis of current strategies.* Copenhagen, Denmark: WHO.

131. Saunders, D. L. & Wanke, M. (1996). Toward a framework for health service research. *Healthcare management forum, 9,* 28-34.

132. Savoie, D. J. (2003). *Breaking the bargain: Public servants, ministers, and parliament.* Toronto: University of Toronto Press.

133. Scheurich, J. J. (1994). Policy archaeology: A new policy studies methodology. *Journal of education policy, 9,* 297-316.

134. Seale, C. (1999). *The quality of qualitative research.* Thousand Oaks, CA: Sage.

135. Shortell, S. (1999). The emergence of qualitative methods in health services research. *Health Services Research, 34,* 1083.

136. Shulock, N. (1999). The paradox of policy analysis: If it is not used, why do we produce so much of it? *Journal of policy analysis and management, 18,* 226-244.

137. Skidelsky, R. (1980). *John Maynard Keynes: A biography*. London: Macmillan.

138. Smith, M. J. (1993). *Pressure, power and polity: State autonomy and policy networks in Britain and the United States*. London: MacMillan.

139. Smith, T. (1991). *The role of ethics in social theory*. Albany, NY: State University of New York Press.

140. Standing Senate Committee on Social Affairs, Science and Technology. (2002). *State of the health care system in Canada*. Ottawa: Senate of Canada.

141. Stehr, N. (2002). *Knowledge & economic conduct: The social foundations of the modern economy*. Toronto: University of Toronto Press.

142. Stingl, M. & Wilson, D. (1996). *Efficiency vs. equity: Health reform in Canada*. Halifax: Fernwood Publishing.

143. Stocking, B. (1995). Why research findings are not used by commissions - and what can be done about it. *Journal of Public Health Medicine, 17,* 380-382.

144. Sykes, J. B. (1987). *The concise Oxford dictionary*. (7th ed.) Oxford, England: Clarendon Press.

145. Taylor, M. (1978). *Health insurance and Canadian public policy: The seven decisions that created the Canadian health insurance system*. Montreal: McGill-Queen's University Press.

146. Tenbensel, T. (2004). Does more evidence lead to better policy? *Policy Studies, 25,* 190-207.

147. Tesh, S. N. (1989). *Hidden arguments: Political ideology and disease prevention policy*. London: Rutgers University Press.

148. Torrance, G. (1998). Socio-historical overview: The development of the Canadian health system. In D.Coburn, C. D'arcy, & G. Torrance (Eds.), *Health and Canadian society* (3rd ed., pp. 3-22). Toronto: University of Toronto Press.

149. United Nations Development Program. (2003). Human development index - An alternative to GDP. Retrieved January 19, 2005, from http://www.undp.org.pl/nhdr_en/index.php?opt=hdi

150. Visser, M. (2002). *Beyond fate*. Toronto: House of Anansi Press.

151. Weber, M. (1946). Science as a vocation. In H.H.Gerth & C. Wright Mills (Eds.), *From Max Weber: Essays in sociology* (pp. 129-156). New York: Oxford University Press.

152. Weber, M. (1947). *The theory of social and economic organization*. New York: Collier Macmillan.

153. Weimer, D. & Vining, A. R. (1999). *Policy analysis: Concepts and practice*. (3rd ed.) Upper Saddle River, NJ: Prentice-Hall.

154. Weller, G. R. (1980). From "pressure group politics" to "medical-industrial complex"; The development of approaches to the politics of health care. In C.A.Meilicke & J. L. Storch (Eds.), *Perspectives on Canadian health and social services policy: History and emerging trends* (pp. 315-341). Ann Arbor, MI: Health Administration Press.

155. Wilensky, H. (1975). *The welfare state and equality*. Berkeley, CA: University of Berkeley Press.

156. Willinsky, J. (2000). *If only we knew: Increasing the public value of social science research*. New York: Routledge.

157. World Bank (1993). *World development report 1993: Investing in health*. Washington D.C.: Oxford University Press.

158. Yin, R. K. (1999). Enhancing the quality of case studies in health services research. *Health Services Research,* 1209-1224.

159. Young, K., Ashby, D., Boaz, A., & Grayson, L. (2002). Social sciences and the evidence-based policy movement. *Social Policy and Society, 1,* 215-224.

160. Zito, A. R. (2001). Epistemic communities, European Union governance and the public voice. *Science and Public Policy, 28,* 465-476.

APPENDICES

Appendix B: Covering Letter to Informants

INTRODUCTION & REQUEST FOR PARTICIPATION

June 20, 2003

Dear

My name is Don Juzwishin. I am a doctoral candidate at the University of Alberta in the Department of Educational Studies. I am undertaking my doctoral thesis on ***Educating Publics and Policy makers: Epistemic Communities and the Politics of Evidence-based Health Reform in Alberta*** and ***Saskatchewan 1987-2003***. In my thesis I am exploring the ways in which evidence and ideology informed and influenced policy and its development in health reform in the provinces of Alberta and Saskatchewan during the years 1987 to 2003. I define high quality evidence as objective, empirically validated information or data. I am seeking to interview people involved in the reform activities as citizens, policy-makers, politicians or researchers. I am doing this because I would like to gain insight and understanding of the different perspectives and approaches these four communities had and how they contributed to the policy-making processes. As part of the project a framework will be developed that will assist policy-makers and politicians assess the quality of evidence that is used to inform policy.

The purpose of this letter is to ask if I may interview you for my research. I will be asking questions (Attachment A) regarding your experiences with and thoughts about the health policy development process. The interview would last approximately two hours and we would meet at a location of your convenience. The interview will be tape-recorded and then transcribed on to paper. You will have the opportunity to review the transcription and make comments or revisions before I use the information to inform my work. The only other person with access to this information will be my supervisor, whose name and contact information is noted below.

I will make every attempt to ensure that your anonymity and confidentiality are respected. No reference will be made to you in the study, as I will be using pseudonyms. All information is for my purposes only and will not be seen by anyone other than my supervisor. You have the option of dropping out of the study at any time if you should choose.

Appendix C: Questionnaire for Informants

1. I am interviewing people who represent the policy-maker, politician, researcher and citizen community in your province. What role did (do) you play in the health reform and policy development process in your province?

2. During the time that you were (are) involved in the health reform policy making process, do you feel that high quality evidence from research played an instrumental role in the formulation of health policy? Why or why not?

3. How do you define high quality evidence that would be used to inform health policy? Examples?

4. In your experience, how would you rate the use of high quality evidence to inform policy development in health reform? Why?
    - Very effective
    - Effective
    - Somewhat effective
    - Ineffective

5. In your experience what factors determine whether evidence is considered high quality or not?

6. What do you feel motivates the current movement toward the use of high quality evidence to inform policy making in health care?

7. What three barriers would you identify that have made it a challenge to bring high quality evidence to inform health care policy?

8. It has been said that more often than not ideology or the influence of vested interests will trump high quality evidence in informing health care policy making. What do you think of this statement?

9. Where would you look if you were wishing to access reputable high quality evidence to inform a health care policy question?

10. What do you think are the sources of evidence that might not be considered to be of a high quality?

11. Do you think there should be an arms length relationship between the production of high quality evidence and health care policy making? Why or why not?

12. Can you differentiate between and among values, ideology, opinion and high quality evidence? How do you do that?

13. If ideology and high quality evidence come into conflict in informing policy, how do you see or have you seen this resolved?

14. How do you perceive the value of the contribution that the four players (policy-maker, politician, researcher & citizen) performed (perform) in the policy development process?

15. Do you feel that the need for high quality evidence for health policy making of the four players is similar or different?

16. In your experience, what factors besides high quality evidence influenced the policy development process?

17. What improvements would you recommend for future health policy development?

18. Do you have any other comments?

19. Do you have any questions?

Appendix D: Guarantee of Confidentiality

I, Donald W. M. Juzwishin, undertake to provide you, ______________________________ as an interview participant in the research project, ***Educating Publics and Policy makers: Epistemic Communities and the Politics of Evidence-based Health Reform in Alberta*** and ***Saskatchewan 1987-2003***, with the guarantee of complete confidentiality.

At no time will your name or other means of identification be divulged. You will be assigned a pseudonym at the outset and this pseudonym will be used in data reporting and analysis.

Every effort will be made to avoid identification through description of particular incidents or occurrences. If, after examining a transcript of your interview, you wish to make changes or have certain material(s) removed entirely from all areas of the study, you have the right to do so.

Researcher's Signature: ____

Date: ________________________________

Appendix E: Letter of Consent to Participate in the Study

Please be advised that I, ____, agree to participate in the research project entitled: ***Educating Publics and Policy makers: Epistemic Communities and the Politics of Evidence-based Health Reform in Alberta*** **and** ***Saskatchewan1987-2003***. This agreement of consent to participate in this study is made subject to the following conditions:

1. That I am aware that:
   - The purpose of this project is to describe and analyze the role of the epistemic community in the process of policy development during health reforms in Alberta and Saskatchewan 1987 and 2003.
   - Data will be gathered through interviews with participants who fall into one of four categories; epistemic community, policy community, political community and citizen community who had first hand knowledge and experience with health reforms in their respective province.
   - Each interview will be recorded and will last between 1.5 to 2 hours.
   - There will be no deception associated with the conduct of this study.

2. That this study is to be conducted according to the Ethics of Research as developed by the University of Alberta and according to the information provided by the approved Research Ethics Review Application of the Department of Educational Policy Studies. Further:
   - My participation in this interview is entirely voluntary and, as a participant I am guaranteed confidentiality. Neither my name nor any other information, which could identify me will be included in the final report.
   - I will be free to withdraw from the study at any time and no information that I have provided will be included in the report or final thesis without my expressed consent.
   - All interviews will be recorded and transcribed to preserve accuracy and assist in the analysis of the data.
   - Following the interview (within 14 days) I will be provided with a transcript of my comments, I will be able to make any revisions I feel necessary, even to the extent of striking certain information from the record.

- I am aware that the name of the researcher is Don Juzwishin and the department/institution to which the study will be submitted is the Department of Educational Policy Studies, University of Alberta, Edmonton.
- I am aware that the academic supervisor of this project is Dr. Jerry Kachur (Department of Educational Policy Studies, University of Alberta) and that Dr. Kachur is willing to answer any questions I may have on this research project. Dr. Kachur's number is 780-492-4427.
- I am aware that this study may be submitted for publication in a peer-reviewed journal.
- An executive summary of the final product will be provided to me in recognition of my assistance in this study.
- My approval to participate in this study is given, subject to the guarantee of confidentiality at the bottom of this form. My signature indicates that I have read this document and understand its contents.

Name of Participant____

Signature____________________________Date:_______________

Researcher's Initials: ____________________

Appendix F: Policy Makers Checklist for Best Practice

Table 33: Best Practice in Research Linking to Policy: Structure and Process

STRUCTURE				PROCESS			
	C	O	N		C	O	N
Build research competency				Teach excellence in PP			
Build research capability				Relevant research			
Build research capacity				Alternatives to peer			
Support $ primary HSR				Relevant research			
Support $ applied HSR				Timely research			
Opportunity for secondments				Open industry conflict			
Incentivize projects				Communicate uncertainty			
Invest in people				Education of public			
Public policy program				International excellence			
Problem solve jointly				Mentor policy makers			
Continuity of projects				Aware excellence			
Leverage federal funds				Field placements			
Leverage international funds				Diversify methods used			
Conflict of interest				Nurture social sciences			
Support field research				Apply 1-3-25			
Partner with other best practice efforts				Gauge public support			
Support infrastructure				Refine and improve process			

Note. HSR = health services research; PP = public policy

Table 34: Best Practice in Research Linking to Health Policy: Outputs and Outcomes

OUTPUTS				OUTCOMES			
	C	O	N		C	O	N
Research projects				Research impacts health			
Publications				Policy maker knowledge up			
Presentations				Marginalized potential up			
Collaborative undertakings				Peer reviewed publications			
Commissioned research				Research relevant			
Conferences				Research QALY up			
Public forum				Increased grants			
Publish 1-3-25				Leverage federal $ up			
Competent graduates				Public knowledge up			
Increasing quality products				Uncertainty decreased?			
Critical results				Research matches priority			
Assess international evidence				Wealth generation up			
Translate knowledge for PM				Intellectual capital up			
Knowledge brokering				Research matches problems			
Improved relationships				Engaged with politicians			
Evaluate outputs				Evaluate impacts			

Note. PM = policy makers ; QALY = quality adjusted life-years.

Table 35: Best Practice in Policy Making: Structure and Process

STRUCTURE				PROCESS			
	C	O	N		C	O	N
Committed leadership				Identify core competencies			
Lead by example				Commission research			
$ for commissioned research				Problematize issues			
Public policy grad. Program				Transparent policy making			
Public meetings on issues				Involve stakeholders			
Information systems available				Diversify inquiry methods			
Staff development supported				Anticipate issues			
Code of practice articulated				Retain important over urgent			
Collaborate with researchers				Collaborate			
Provide data to researchers				Public consultation			
Information specialists avail				Survey and poll citizens			
Open provincial health council				Citizen juries			
Staff development				Deliberative polling			
Fund NGOs arm's length				Value analysis			
Support networking				Acquire high-quality evidence			
Support for maintaining BP				Apply social sciences + ethics			
Support of refining BP				Improvement opportunities			

Note. NGOs = nongovernmental organizations.

Table 36: Best Practice in Policy Making: Outputs and Outcomes

OUTPUTS				OUTCOMES			
	C	O	N		C	O	N
Publish annual health goals				Improved health status of pop.			
Progress on health goals				Improved QALY			
Public forum on health issues				Reduced risk of pop. to disease			
Indicators of provincial health				Progress relative to health goals			
Performance of providers				Increased public involvement			
Strategic challenges 5 – 10 yrs				Health of marginalized			
Performance of health regions				Identify who wins/loses			
Minutes of meetings				Increased public awareness			
Medium-term goals – 25 yrs				Increased public satisfaction			
Long-term goals – 50 years				Increased healthy lifestyles			
Report access to health				Critical awareness of citizens			
Award policy competence				Improved Aboriginal health			
Financial accountability				% Independence of disabled			
Award innovation				HDI comparators (international)			
Evaluate BP results				People under the poverty line			
Identify areas of improvement				Assess impact of health policy			

Note. BP = best practices; HDI = human development index; QALY = quality adjusted life-years.

Table 37: Meaningful Linkages: Structure and Process

STRUCTURE				PROCESS			
	C	O	N		C	O	N
Create networking opportunity				Introduce network grants			
Graduate program in PP				Meet researchers and PM			
Grand rounds on PP				Help groups communicate			
Field placements				National international ex.			
Registries of evidence				Explain research process			
Public consultations				Commit time for linkage			
Embedded org. entities				Organize workshops			
Stakeholder consultations				Act as knowledge broker			
Increase NGOs in research				Promote use of evidence			
Support SEARCH				Bulletin board service			
Access to licensed data bases				Actively disseminate			
Video conferencing				Email list serve			
Cross appointments				Encourage openness			
Sabbatical for policy maker				Sustain info exchange			
Place academic in policy				Study tours			
Incentivize linkages				Improve communications			
Evaluate effectiveness				Monitor and assess links			

Note. HDI = human development index; NGOs = nongovernmental organizations; PM = policy makers; PP = public policy; QALY = quality adjusted life-years.

Table 38: Meaningful Linkages: Outputs and Outcomes

OUTPUTS				OUTCOMES			
	C	O	N		C	O	N
Collaborative projects up				Increased awareness			
Projects multidisciplinary				Impact on population health			
Politicians involvement up				Improved QALY			
National linkages increased				Increased public awareness			
International linkages up				More students aware of link			
Workshops				Academic staff involved up			
Collaborative priority setting				Policy staff involved up			
Targeted seminars				Increase funding for linkage			
Outputs in plain language				Liaison committee # up			
Policy maker involvement up				Knowledge broker # up			
Researcher involvement up				Research programs +5 years			
Assist identify priority themes				Satisfied network members			
Best practices in linkages				Research receptors # up			
Fewer surprises in sectors				Improved knowledge			
Increased interest				Increased incentives			
Assess outputs				Behaviour change			

Note. QALY = quality adjusted life-years.

Table 39: Accommodation: Structure and Process

STRUCTURE				PROCESS			
	C	O	N		C	O	N
Structures facilitate discourse				Open dialogue of issues			
Multidisciplinary involve				Many voices invited			
Leadership by example				Values speak to evidence			
Accountabilities are clear				Ideology raised explicitly			
Meetings facilitate openness				Transparent policy making			
Stakeholders invited				Political evidence is NB			
Embedded structure				Mgt. issues to research			
Regular meetings				Value judgments made			
Published minutes				Risk managed openly			
Submissions accepted				Expand types of evidence			
Citizen input solicited				Marginalized have voice			
Citizen juries				Opinions to be informed			
Deliberative polling				Assist DM prioritize			
Priorities set explicitly				Pragmatic decision occur			
Televise deliberations				Policy making explicit			
Public consultation				Citizen sentiment captured			
Evaluate structure and process				Politics made explicit			

Note. DM = deputy minister; NB = important.

Table 40: Accommodation Outputs and Outcomes

OUTPUTS				OUTCOMES			
	C	O	N		C	O	N
Collaborative policy				Improved policy making			
Clear accountability				Improved health status			
Socially just policy				Improved QALY			
All voices satisfied process				Public satisfaction up			
Informed public				Marginalized health state up			
Clear explanations of policy				Satisfied politicians			
Social demographics account				Satisfied policy makers			
Technology effectiveness				Increased trust of providers			
Environment implications				Increased trust of public			
Economic results – impacts				Increased trust of citizens			
Political impacts				Increased trust of researcher			
Legislative implications				Social sciences involved +			
Social ethical implications				Social ethics involved +			
Annual progress report				Respond to challenges +			
Next years objectives				Identify new challenges			
Evaluate outputs				Evaluate outcomes			

Note. QALY = quality adjusted life-years.

Table 41: Effective Traction: Structure and Process

STRUCTURE				PROCESS			
	C	O	N		C	O	N
Monitor population health				Public health vision			
Publicly report				Public health goals			
Monitor marginal group health				Health promotion			
Monitor goal performance				Disease prevention			
Provide opportunity for input				Public health initiatives			
# Unanticipated health issues				Managing chronic disease			
Health system performance				Continuum of service			
Health governance performance				Identify at risk population			
Economic performance				Encourage QI			
Testing fiscal capacity				Encourage innovation			
Health provider performance				Remove obsolescent tech			
Adverse incident reporting				Remove ineffective tech			
Regulation of unsafe interventions				Remove inappropriate technology			
Diffusion of ineffective tech				Encourage critical conscience.			
Cross border migration for ser				Undertake audits			
International movement				Conduct review			
Reporting on system perform				Conduct evaluations			

Note. QI = quality improvement.

Table 42: Effective Traction: Outputs and Outcomes

OUTPUTS				OUTCOMES			
	C	O	N		C	O	N
Annual reports – health status				Population health change			
Multiyear trends				Marginal group health change			
Morbidity data				Access to services			
Mortality data				Portability of health service			
Adverse events in HS reports				Comprehensiveness of HS			
Regional variation of service				Health risk managed			
Provider performance by region				Effective interventions			
Regional variation of complications				Benchmarking encouraged			
Utilization of HS province wide				Successful programs noted			
Access to services by DRG				Potential for health just			
Complication rate provider				Provider satisfaction HS			
Complication rate by RHA				Class distribution of disease			
Economic performance				Risk-taking behaviour			
Small area analysis				Healthy lifestyle behaviour			
Emerging health issues				Citizen satisfaction with HS			
Evaluation of traction outputs				Evaluation of traction			

Note. DRG = diagnostic related groupings; HS = health services; QALY = quality adjusted life-years; RHA = regional health authority.